NPU-V Health Scan

July, 2009

Prepared for the Atlanta Civic Site
& the Annie E. Casey Foundation

mosaic
GROUP

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I. Introduction

The Atlanta Civic Site is one of three civic sites around the country designated and supported by The Annie E. Casey Foundation. The civic sites are places where the Foundation has made a long- term commitment to promote neighborhood-scale programs, policies, and activities that contribute to strengthening families and supporting neighborhoods.

Started in 2004, the work of the Atlanta Civic Site has three main goals:

- Education achievement.
- Family economic success.
- Neighborhood transformation.

Significant progress has been achieved in each of the above three goal areas in the last five years. While working across these three areas the Atlanta Civic Site recognized health as an important factor to continue to advance results for children and families.

Health is critical for all residents to achieve an optimal quality of life but for children especially, promoting healthy growth and development provides the foundation from which children can engage in activities that stimulate their physical, cognitive and social development (Pati, Hashim, Brown, Fiks and Forrest, 2009). In order to identify how best to integrate health strategies into the existing and future work of the Atlanta Civic Site, the leadership engaged Marla Oros and Colleen Hosler of The Mosaic Group to conduct a comprehensive health scan of the NPU-V neighborhood in February, 2009.

The health scan gathered data and information across a multitude of domains that are known to impact the health status of children and families. Quantitative data collection and analysis of demographic and neighborhood level indicators was conducted to understand the relationship between these variables and the health status of NPU-V residents. This is important as it is well documented that socioeconomic status is associated with high rates of chronic diseases and mortality (Adler & Ostrove, 1999; Centers for Disease Control and Prevention, 2002). In the U.S. the health of children varies widely across racial/ethnic, socioeconomic and geographic domains. Poverty has been established as an important predictor of risk of mortality during infancy and throughout childhood and contributes to the leading causes of death at these ages including peri-natal conditions, congenital anomalies, motor vehicle injuries and homicides (Hillemeier et al, 2003).

The scan also collected and analyzed data on key health indicators to determine the primary health disparities impacting children and families in the NPU-V. A primary goal of Healthy People 2010, the federal government's major national initiative to improve health, is to reduce and eliminate health disparities, specifically along racial and ethnic lines. As a neighborhood that is comprised primarily of African American families living in poverty, it is clear that health disparities exist and result in less than optimal productivity, well-being and even lifespan for residents of the NPU-V. Nationally, research indicates that minorities and the less educated have higher mortality rates for a wide range of diseases, including stroke, diabetes, hypertension, cancer, heart disease, lung disease and HIV/AIDS (Wong et. al, 2002). Therefore, analysis of the population's health indicators is critical to identification of the major health issues impacting the NPU-V neighborhood.

Poor children, like those in the NPU-V also are compromised in their access to health care and resulting health status. In 2007, over 15 million children nationally–one out of every five–lived in poverty (Children's Defense Fund, 2008). More than half of all poor children in the U.S live in eight states: California, Texas, New York, Florida, Illinois, Ohio, Michigan and Georgia.

Children who live in poverty are more likely to suffer from bad outcomes in health care and education. According to Sherman (1997), children who live in poverty are:

- Approximately twice as likely to die in childhood compared to children who do not live in poverty.
- 2.7 times more likely to suffer from stunted growth.
- Three to four times more likely to suffer from iron deficiency compared to children who do not live in poverty.
- One to two times more likely to become partly or completely deaf, blind, or suffer from serious physical or mental disabilities.
- More likely to score lower on IQ tests.
- More likely to suffer from learning disabilities.
- More likely to perform below usual grade for their age group.
- More likely to drop out of school.

Children who live in poverty are also less likely to have health insurance and thus have less access to health care and health services. In 2000, approximately 18 percent of all poor children in the country–had no health insurance coverage and therefore could not optimally access health care services. In order to understand access to care issues in the NPU-V, the health scan included a comprehensive inventory and profile of health services and supports available to NPU-V children and families. Key informant interviews with stakeholders in the community and providers of health care services were conducted as well to contribute to a summary of the major health needs and issues impacting children and families in the NPU-V and recommendations for future intervention.

The following report will:

- Describe the methodology used to obtain the data.
- Examine the demographics of the NPU-V.
- Review the pertinent health data to obtain a snapshot of NPU-V and the surrounding area.
- Analyze findings of data to support identification of major health issues.
- Generate an inventory and profile of available health services.
- Identify gaps in health services and foundational programs for future partnership.
- Summarize findings of the health scan.
- Recommend future actions.

II. Methodology

The methodology used to conduct the NPU-V health scan included the following:

- Quantitative analysis of key demographic and health data.
- Inventory and profile of services and supports.
- Gap analysis of health services.
- Qualitative analysis of major health issues through key informant interviews.

The quantitative assessment included a review and analysis of neighborhood demographic data, maternal child health indicators, childhood disease outcomes and child and adult mortality data. Data was collected and analyzed on the current NPU-V population and the health needs of the children and their families with a focus on children ages 0-21. Information was gathered from a variety of sources including the Fulton County Health Department, Georgia Department of Health, the Annie E. Casey Foundation Neighborhoods Count publication, university reports and other previous documents containing relevant data for the scan. The NPU-V health scan contains only data from secondary sources such as those just indicated. No primary data was gathered for this report. Data sources and notes are presented at the bottom of each table and chart. Because NPU-V encompasses a partial combination of three zip codes, comparisons are made throughout the scan between NPU-V, Fulton County, Atlanta and the State of Georgia. These comparisons allow for more accurate reflection into the depth of issues in the community.

An inventory of services and supports available in the community and surrounding areas was collected through scans of websites, related web searches, contacts with health service providers, review of provider literature and interviews with community health leaders. This inventory and profile was used to identify key service gaps that may exist in the neighborhood that impact the health status of children and families. The inventory and profile also identifies programs that are working well for children and families and could potentially be partners with the Atlanta Civic Site in their efforts to address health needs. Interviews with key stakeholders were conducted to identify additional needs and

issues from policy leaders, program administrators, community residents and practitioners.

The findings of this data collection and inventory of services are summarized in later sections to guide the determination of the priority health needs for the children 0-21 and their families in the NPU-V.

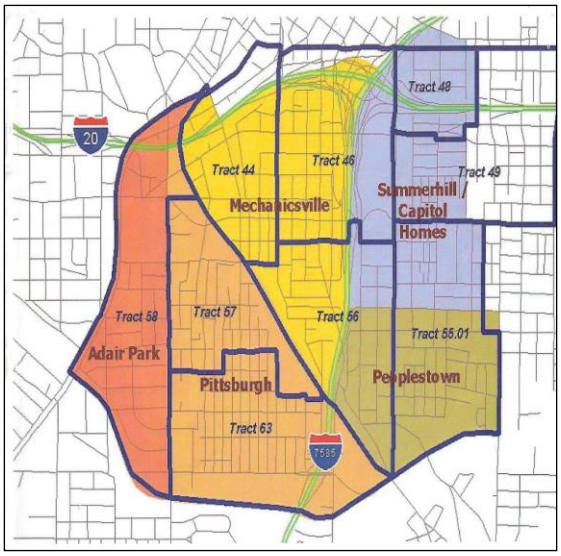
III. Neighborhood Profile

The neighborhood profile includes an overview of the NPU-V neighborhood characteristics, a geographic profile, analysis of population data, an economic and employment profile, and a presentation and analysis of the leading health indicators.

A. Geographic Profile

The targeted geographic area for the health scan is Neighborhood Planning Unit-V (NPU-V). The NPU-V is located slightly south of downtown Atlanta and encompasses an approximately 3.5 square mile area. The NPU- V includes the five Atlanta neighborhoods of Adair Park, Mechanicsville, Peoplestown, Pittsburgh, and Summerhill/Capitol Homes. These neighborhoods are some of Atlanta's oldest residential areas. The NPU-V consists of parts of zip codes 30310, 30312 and 30315. The census tracts are as follows:

- 13121004400
- 13121004600
- 13121004800
- 13121004900
- 13121005501
- 13121005600
- 13121005700
- 13121005800
- 13121006300



B. Population Size

According to the U.S. Census Bureau, (2000) the NPU-V has a total population of 15,825. The total population of the NPU-V declined approximately 1% between 1990 and 2000 (Table 1). The overall population growth over the last ten years has been flat with only a slight increase in the population of children and a slight decrease in the elderly population.

Summerhill-Capitol Homes is the largest community in the NPU-V with 4,320 people but showed only 2.8% growth, while Adair Park, the smallest neighborhood had the largest growth between 1990 and 2000 (29%). Peoplestown showed slightly higher growth than Summerhill-Capital Homes (5.1 %). Mechanicsville and Pittsburgh neighborhoods both showed declines in population by 13% and 9% respectively. Between 1990 and 2000 Atlanta, Fulton County and Georgia all saw population growth.

Table 1 **Total Population of the NPU-V by Neighborhood; 2000**

	Adair Park	Mechanics-ville	Pittsburgh	Summerhill/Capitol Homes	Peoples town	NPU-V	Atlanta	Fulton County	Georgia
Total Population, 2000	**2,205**	**3,358**	**3,286**	**4,320**	**2,656**	**15,825**	**486,411**	**1,014,932**	**9,865,744**
Population Change since 1990	**29%**	**-13%**	**-9.3%**	**2.8%**	**5.1%**	**-1%**	**8%**	**24.4%**	**18.3%**

Source: U.S. Census Bureau, 2000, Atlanta Community Access Coalition; 2002

C. Age, Race and Gender

Data on age and race/ethnicity of the NPU-V residents is important to understand because of the well documented correlations between age, race/ethnicity with health risks and

health outcomes discussed in Healthy People 2010. Overall, the NPU-V is a predominantly African American community with a slightly larger female than male population and a sizeable population of children under the age of eighteen.

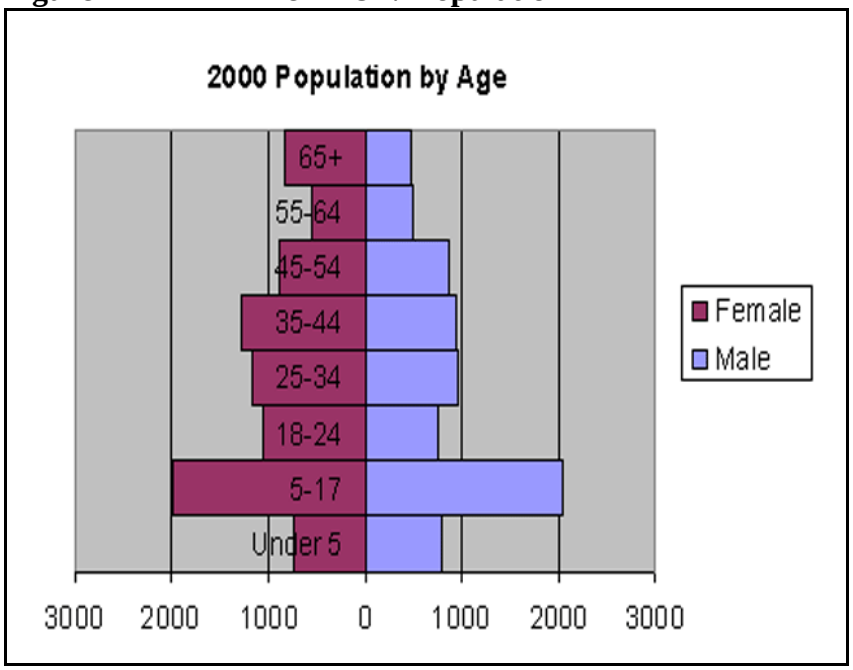
1. Age

It is important to understand the breakdown of the population of children living in the NPU-V by age cohort as the health needs of children are very different across developmental ages and stages beginning at birth.

In 2000 there were 5,548 children under the age of eighteen, comprising approximately 35% of the NPU-V population (Figure 1). This is substantially higher than the percentage of children in Atlanta, which account for 22% of the population. Approximately 18 percent of the children are under the age of five.

The NPU-V population of working age adults between the ages of 18-64 years comprises approximately 56 percent of the neighborhood, somewhat smaller than the 63 percent in Atlanta. The elderly population consists of 8 percent of the population, similar to Atlanta's 10 percent (Atlanta Neighborhood Change Report-Georgia Tech.). The median age of the population of NPU-V in 2000 was 26.6 years.

Figure 1 The NPU-V Population



http://www.arch.gatech.edu/~dapa/reports/atlneighchg/page-Images/npuv.html

2. Race

Understanding the racial composition of a neighborhood is important as research indicates that minorities, especially minority children suffer disproportionately from

chronic and preventable health conditions. Prior studies demonstrate the following as it relates to African American children and families compared to whites:

- Higher rates of infant mortality and low birth weight babies.
- Higher rates of elevated blood lead levels leading to developmental and educational disabilities.
- Less access to early prenatal care.
- Higher rates of emergency room use and hospitalization for asthma.

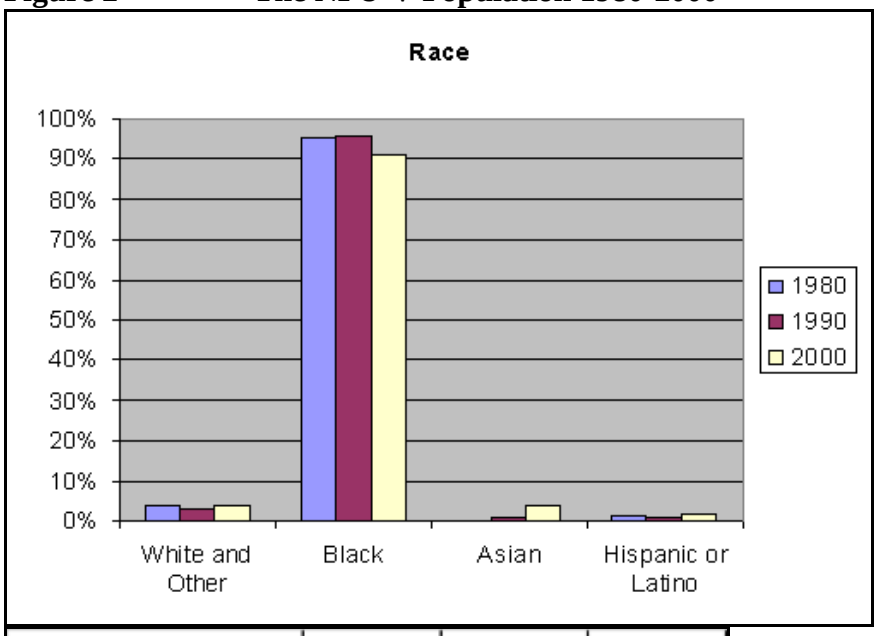
The racial composition of NPU-V is 92% African American, 3% Caucasian and 4% other races. The five neighborhoods of NPU-V are similar in racial composition with Pittsburgh having a slightly higher African American community (96%) than the other neighborhoods (Table 2).

The percentage of African Americans living in the NPU-V is significantly higher than Georgia, Atlanta and Fulton County. In 2000, the racial composition of Atlanta was 61.4% African American, 33% Caucasian and 5% other races. Fulton County was approximately 43% African American and 51% Caucasian. The state of Georgia had a population increase of 18.3% and was 30% African American and 65.6% Caucasian (Table 2). Thus, Atlanta and Fulton County are much more racially diverse then the NPU-V and its neighborhoods.

Table 2 **Population of the NPU-V by Race; 2000**

	Adair Park	Mechanics-ville	Pittsburgh	Summerhill/ Capitol Homes	Peoples town	NPU-V	Atlanta	Fulton County	Georgia
Percentage of Population African American	73	93	96	94	93	92	61.4	42.9	30
Percentage of Population Caucasian	8	3	2	4	3	3	33.2	51.3	65.6
Percentage of Population Other Race	19	4	2	2	3	4	5.4	5.8	5

Figure 2 The NPU-V Population 1980-2000



	1980	1990	2000
Total	18,268	15,960	15,825
White and Other	4%	3%	4%
Black	95%	95%	91%
Asian	0%	1%	4%
Hispanic or Latino	1%	1%	2%

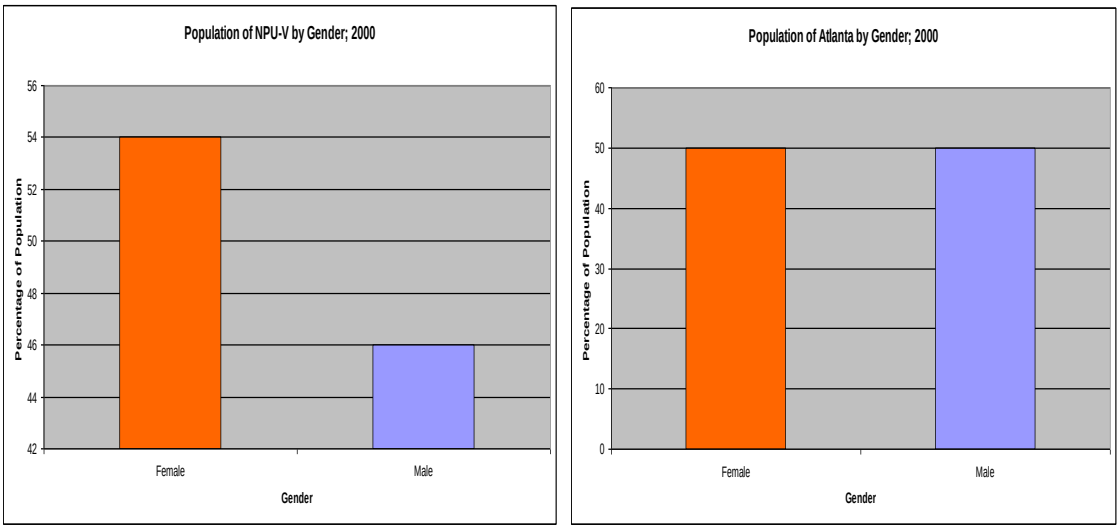
http://www.arch.gatech.edu/~dapa/reports/atlneighchg/page-Images/npuv.html

The NPU-V has retained a large African American population since 1980 (Figure 2). Figure 2 illustrates that the African –American population in the NPU-V decreased slightly in each decade between 1980 and 2000 while still comprising 90% of the population. The Asian and White population increased slightly while neither group rose above 5% (Figure 2). Adair Park is the most racially diverse of the NPU-V neighborhoods with 73% African American population, 8% Caucasian and 19% other races.

3. Gender

According to the 2000 U.S. Census Bureau, the population of the NPU-V consists of 54% females and 46% males. This is similar to the population of Atlanta which is made up of 50% females and 50% males (Figure 3).

Figure 3



Source: U.S. Census Bureau, 2000

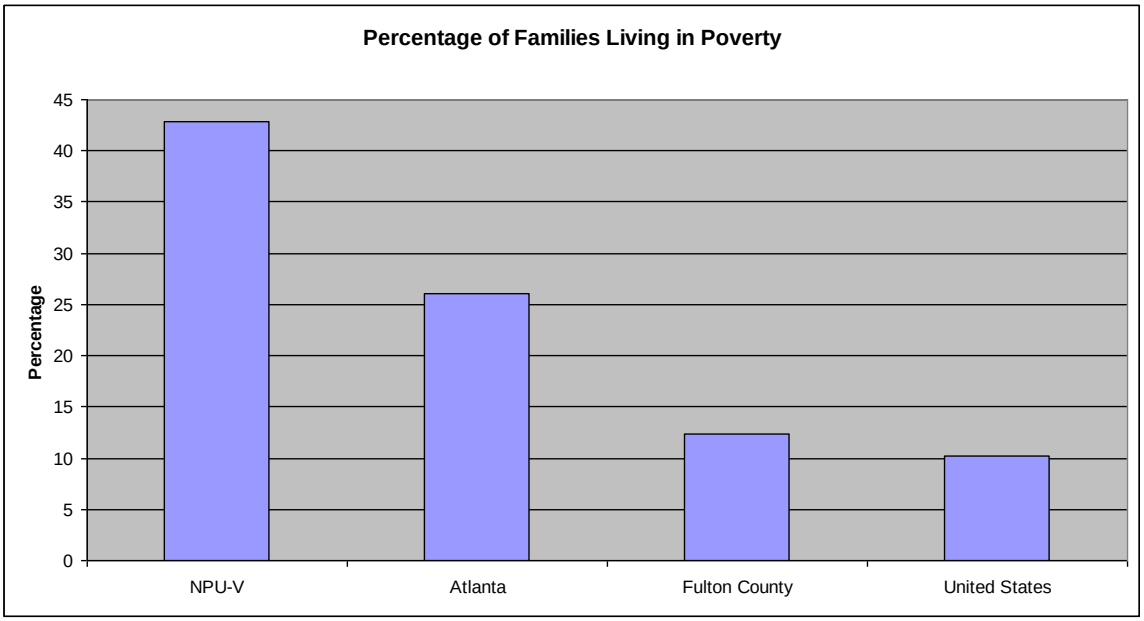
D. Economic Profile

The association between neighborhood characteristics, family resources and children's health outcomes has been well documented (Brooks-Gunn et al., 1997). For example, children who live in poverty are less likely to have health insurance and have less access to health care and thus suffer poorer health outcomes (Patel, 2001).

There are a number of socio-economic factors in the NPU-V that effect the community's health outcomes. The first is poverty. There are higher rates of poverty within the NPU-V than Fulton County, Atlanta, Georgia and the U.S. The rate of families living in poverty in the NPU-V is four times greater then the rate of families living in poverty in the U.S. and three times greater then Fulton County:

- 42.8 % of families in the NPU-V are living below the poverty line compared to the following (Figure 4):
  - 26% of the families in Atlanta.
  - 12.4% of the families in Fulton County.
  - 10.2% of the families in the U.S.

Figure 4



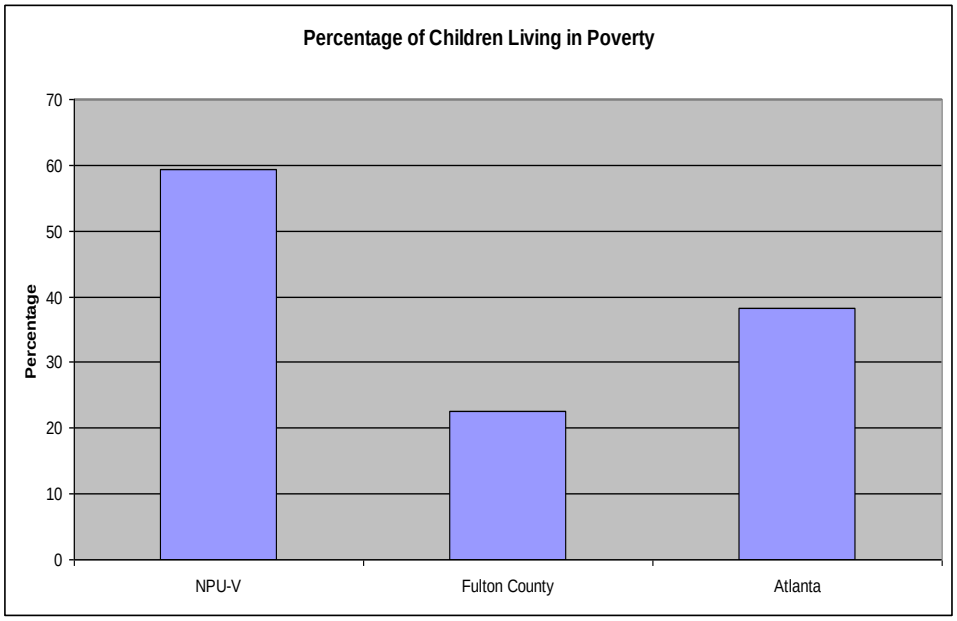
Source: U.S. Census Bureau, 2000

The percentage of children in the NPU-V that live in poverty is significantly higher than Atlanta, Fulton County and the U.S. Nearly 60% of the children in the NPU-V live in poverty:

- Fulton County - 22.6%.
- Atlanta- 38.3%.
- U.S. - 10%.

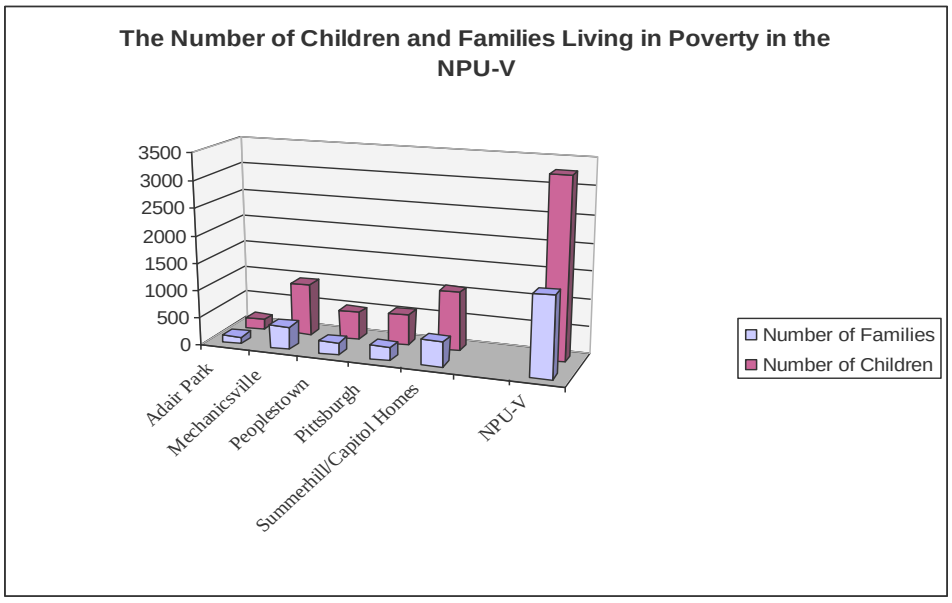
The highest percentages of children living in poverty in the NPU-V were from Mechanicsville (68.7%) and Summerhill/ Capitol Homes (68.4%), while Adair Park (31.1%) had the lowest percentage of children living in poverty (Figure 6).

Figure 5



Source: U.S. Census Bureau, 2000

Figure 6

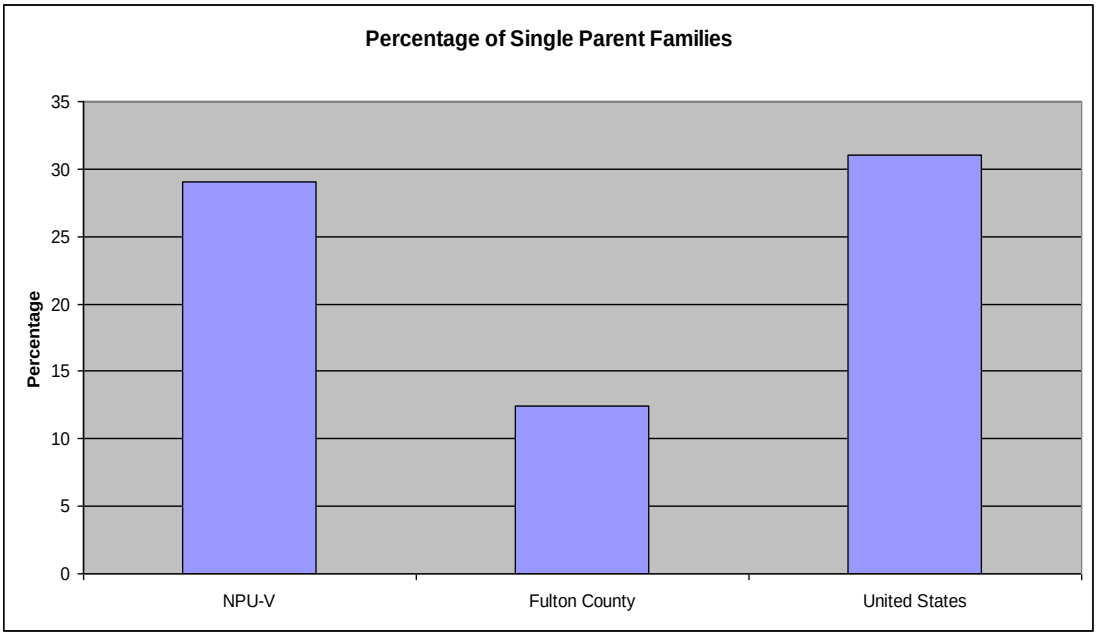


Source: ***U.S. Census Bureau, 2000***

Children living in single-parent families are more likely to live in poverty than children living in two-parent families. In the NPU-V, 52.9 percent of children under the age of six living with a single mother lived in poverty. This is more than five times the rate of their counterparts in two-parent families. In the NPU-V, single–parent families accounted for

29% of all households, compared to 13% in Fulton County and 31% in the U.S. (Figure 7).

Figure 7



Source: U.S. Census Bureau, 2000

Median household income is another socio-economic determinant that factors into the community's health outcomes. Low maternal education and low family income are the two most prevalent risk factors at both nine and twenty-four months of age. According to Halle et al. (2009), infants and toddlers from lower- income families:

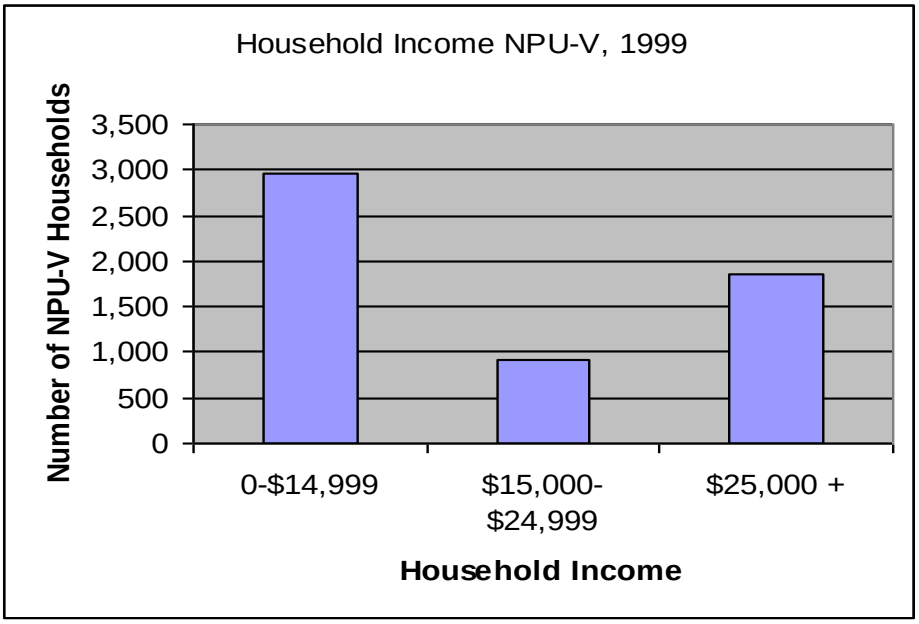
- Score lower on cognitive assessments than their peers from higher-income families.
- Are less likely to have their parents report in very good or excellent health than their peers from higher-income families.
- Are less likely to have a secure attachment to their primary caregiver than their peers from higher-income families.
- Are more likely to have lower positive behavior ratings at nine and twenty-four months than their peers from higher-income families.

Like the poverty data reported above, the NPU-V neighborhood has significantly higher rates of low income families than Atlanta and the country. In the U.S., the median household income in 1999 was of $41,994 and Atlanta had a median household income of $34,770 in 1999 (U.S. Census Bureau, 2000).

In 2000, 68% of the households in the NPU-V had an annual income of $24,999 or less (Georgia Division of Family and Children Services, TANF; U.S Census Bureau, 2000) (Figure 8). Within the NPU-V there are:

- 2,968 households with incomes between $0 and $14,999.
- 921 households with incomes between $15,000 and $24,999.
- 1,859 households with incomes greater that $25,000.

Figure 8



Source: U.S. Census Bureau, 2000

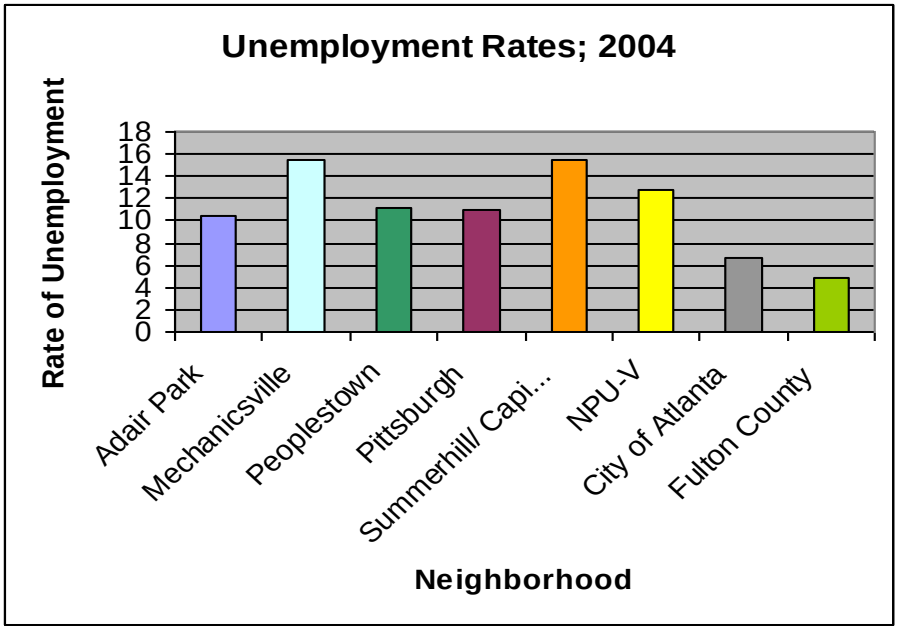
E. Unemployment

Measures of poverty status such as parental employment offer insight into the well-being of children and factors that effect their health and development (America's Children in Brief: Key National Indicators of Well-Being, 2008). Parental employment reduces the likelihood of low socio-economic status. Families with low socio-economic status (SES) are more likely to be uninsured and/or underinsured compared to families with higher SES. Low SES families and individuals consistently have poorer health than higher SES individuals and families (Chen et al., 2006). Additionally, low SES has been associated with high rates of many chronic diseases and higher rates of mortality (Kennedy et al., 2007). Low SES children are less likely to receive vaccinations or to have medical homes (Chen et al., 2006). Understanding these relationships is critical for maximizing children's health and for understanding the origins of adult health disparities.

Family income and employment are strong predictors of SES. As shown in Figure 9, the NPU-V has consistently high levels of unemployment across all five communities. The communities of Summerhill/Capitol Homes and Mechanicsville have the highest rates of

unemployment within the NPU-V. In 2004, the unemployment rate for NPU-V was 12.8%, which was much higher than the 6.7% rate for Atlanta. The economic downturn in the U.S. since 2007 has most likely led to an increase in these numbers.

Figure 9



Source: U.S. Census Bureau, 2000

In 2000, there were close to 11,000 working age adults in the NPU-V (Table 3). This includes 5,482 adults that are not in the labor force, 1,143 unemployed adults and 4,351 employed adults. This data illustrates that nearly one-third of the NPU-V population is not in the labor force.

Table 3

NPU-V Labor Force Composition, 1990-2000				
	1990		2000	
	Male	Female	Male	Female
Total in Labor Force	2730	2671	2614	2881
Employed	2247	2190	2090	2261
Unemployed	483	481	522	621
Not in Labor Force	2181	3547	2279	3203

Source: U.S. Census Bureau, 2000, Atlanta Community Access Coalition; 2002

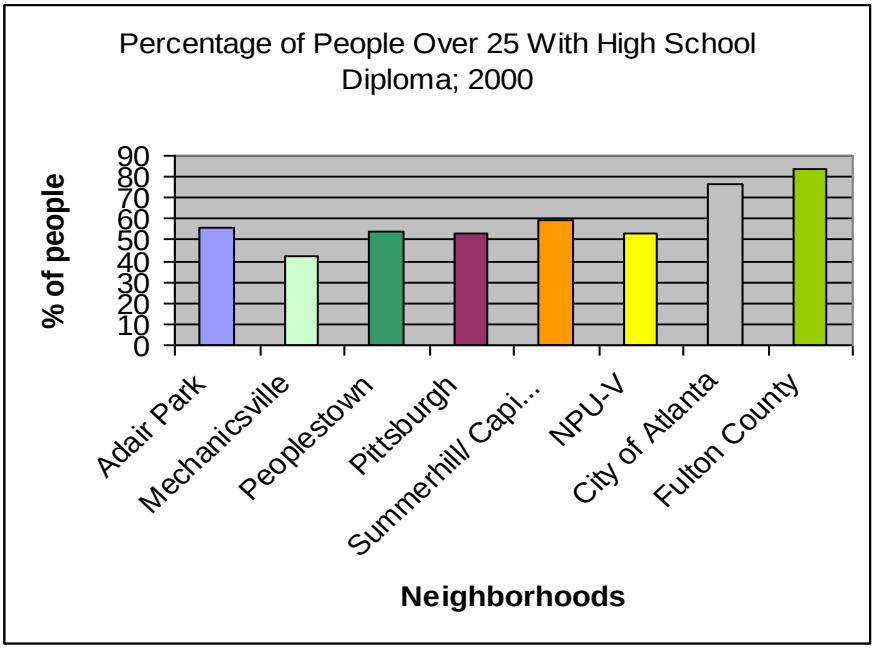
F. Educational Profile

Parental education level contributes to socio-economic status and is another important factor contributing to the health of children (Kennedy et al., 2007). As indicated previously, low maternal education and low family income are the two most prevalent risk factors at both nine and twenty-four months of age (Halle et al., 2009). Children with parents with less than a high school diploma show disparities as early as nine months of age across multiple domains of development, including cognitive development, social-emotional development, and general health. Furthermore these disparities become more prominent by twenty-four months of age. Parents with higher levels of education are more likely to have jobs with health insurance benefits and are more likely to be educated about the importance of well-child visits and preventive medicine.

The most recent data from 2000 shows that in the NPU-V (Figure 10):

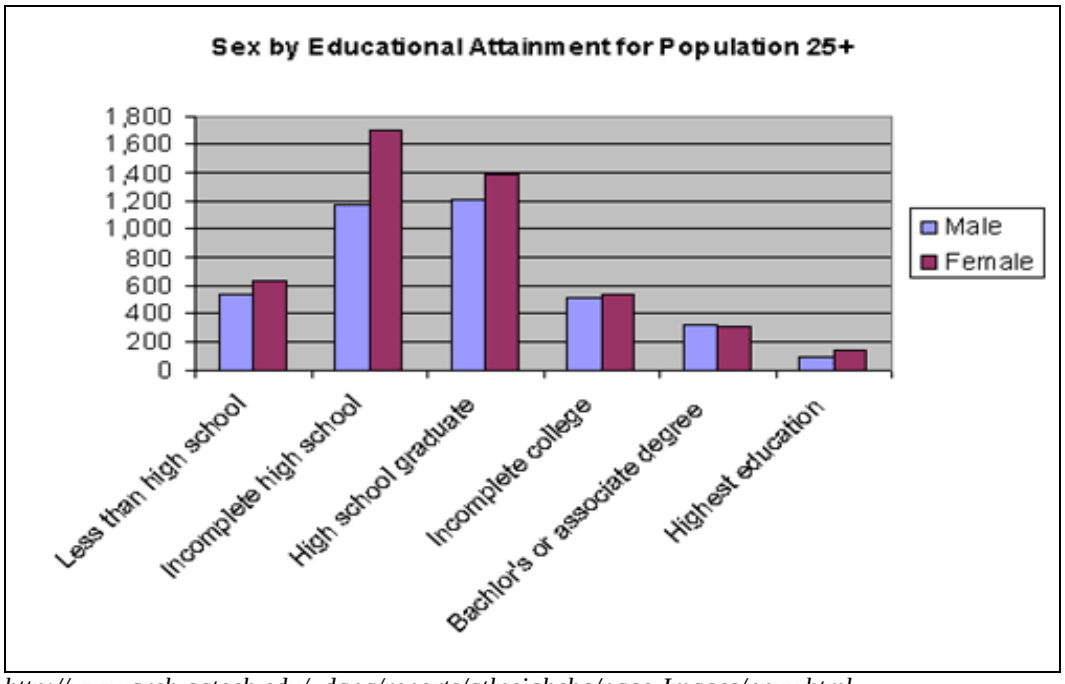
- 53% of residents 25 years and older have a high school diploma, compared to Fulton County with 84% and Atlanta with 76.9%.
- Mechanicsville has the lowest percentage, with 42.1% and Summerhill/ Capitol Hill the highest at 59%.
- Only 22.3% of the residents age 25 and older in the NPU-V have a postsecondary education compared to Fulton County at 64.6% and Atlanta at 54.6%.
- NPU-V has a disproportionately low number of people with high school diplomas compared to Atlanta and Fulton County.
- 25% of the residents of Atlanta have associate's or bachelor's degrees compared to less than 5% of the NPU-V residents who hold these degrees.
- Similar numbers of males and females in NPU-V complete higher education degrees (Figure 11). Females in the NPU-V are more likely than males to drop-out of high school, while those that stay are more likely than their male peers to graduate.

Figure 10



Source: U.S. Census Bureau, 2000

Figure 11



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G. Housing Profile

Low income and/or minority communities that are already burdened with greater rates of disease, limited access to healthcare and other health disparities are usually the same populations living in the worst environmental conditions. According to Ellen et al. 2001, negative neighborhood and housing environments tend to interact with and magnify already difficult health conditions leading to increased risk of the following:

- Crime and violence.
- Exposure to lead.
- Overweight and obesity.
- Mental health disorders.
- Pollution of the air, water and soil.
- Electrical and other environmental hazards to children.
- Asthma exacerbations from environmental irritants such as dust mites, cockroaches, rodents and mold.

During the 1990's Atlanta's population increased and subsequently its housing by 6% and 8% respectively, while the NPU-V population declined. According to the Center for Working Families, in 2008, there were 2,396 vacant or unoccupied houses in the NPU-V, nearly 42% of all homes in the neighborhood. This is an increase from 13% vacant housing units in 2000.

In recent years large housing developments such as Capitol Homes and McDaniel Glen have either been torn down or are slated for demolition. During the early years of 2000, NPU-V developers attempted to get in on the booming housing market and develop new homes however today many of those homes sit vacant having never been lived in.

H. Health Indicators

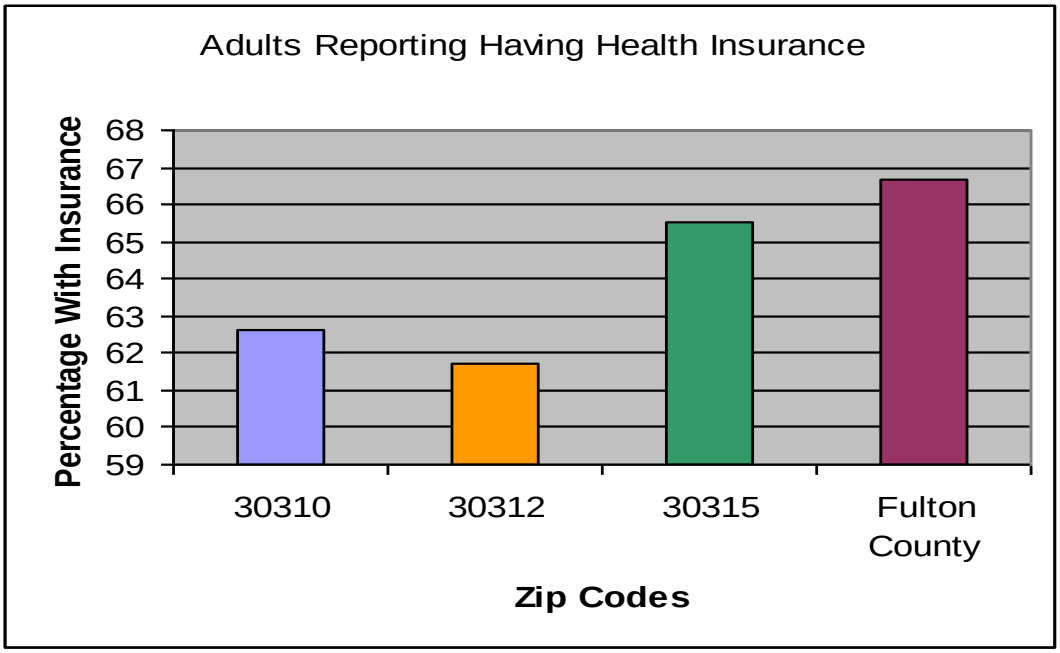
The previous section outlined the demographic picture of the NPU-V including poverty, age, race, economic, education and housing. This section will focus on understanding the leading health indicators of children and families living in the NPU-V.

1. *Insurance Coverage*

The first indicator assessed is access to health insurance. Access and availability of health insurance has a direct effect on the health status of children and families. According to Patel (2001), children who live in poverty are less likely to have health insurance and thus less access to health care. While the federal government has significantly expanded health insurance coverage for children through the Children's Health Insurance Program, many children remain uninsured due to barriers to enrollment. Low income adults and the working poor continue to be disproportionately uninsured in the U.S., while the nation considers how best to address universal access.

In the three NPU-V zip codes, an average of 62.3% of adults report having health insurance (Figure 12), leaving a considerable percentage of the adult population without access to care. In zip codes 30310 and 30312, the statistics are much worse, where residents reported much lower rates of health insurance access. All three zip codes show lower rates of coverage compared to Fulton County.

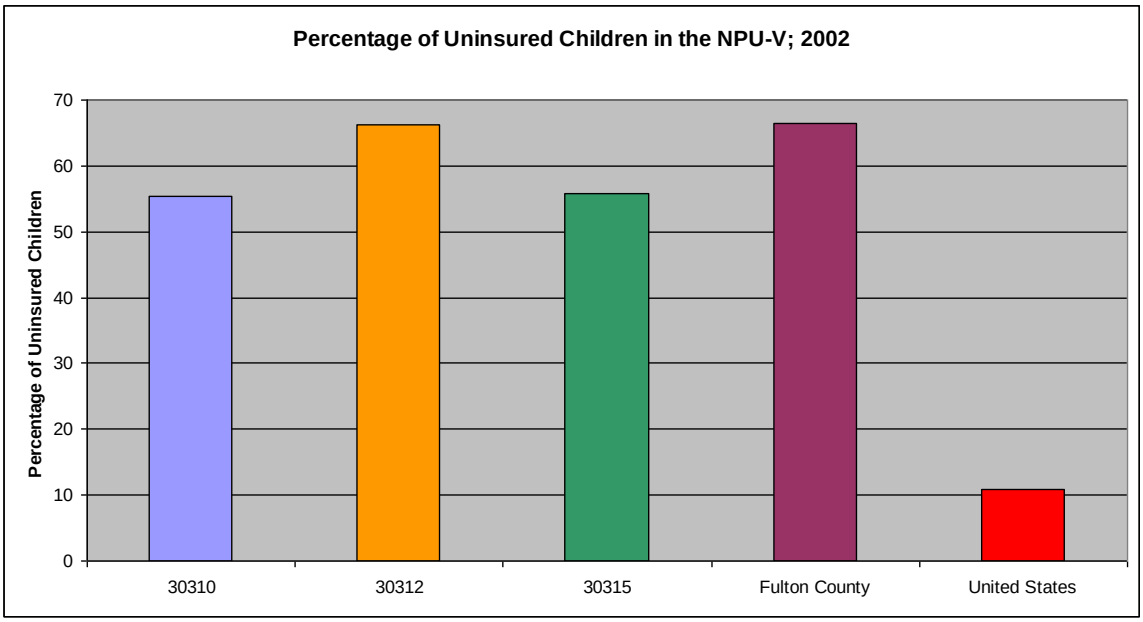
Figure 12



Source: Atlanta Community Access Coalition; 2002

According to the Atlanta Community Access Coalition, in 2002, the percentage of uninsured children in the three zip codes of the NPU-V was higher than the percentage of uninsured adults. The percentage of uninsured children in the NPU-V is approximately five times higher than the number in the U.S. (Figure 13).

Figure 13



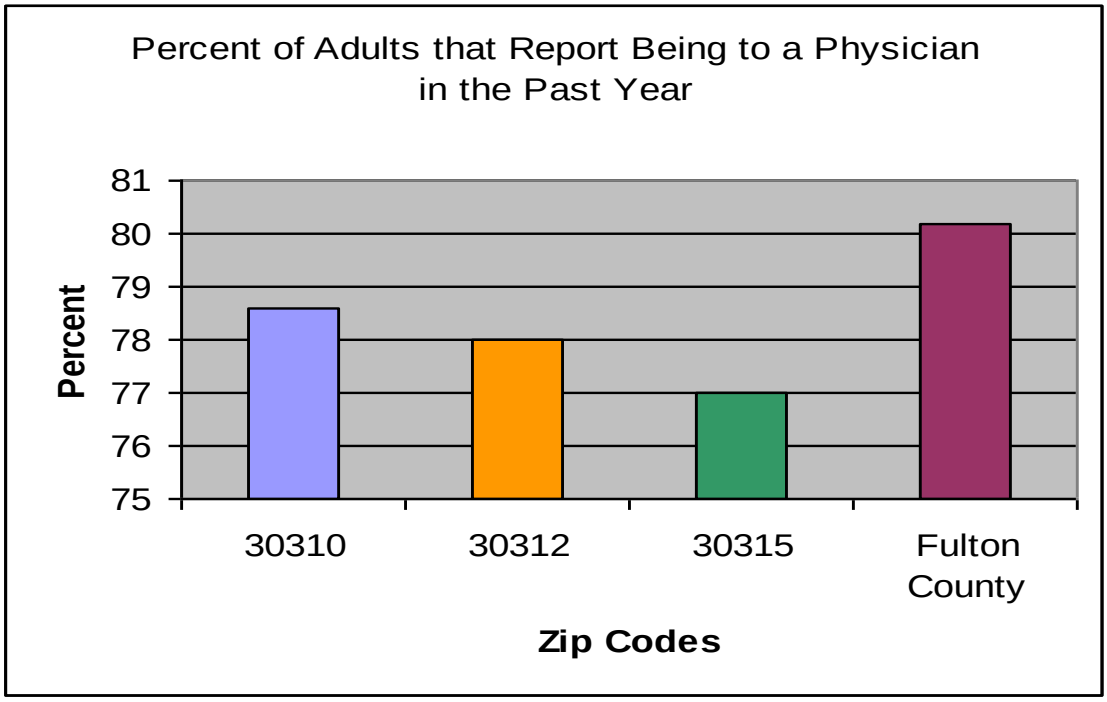
Source: Atlanta Community Access Coalition; 2002

2. *Primary Care Access*

The contributions of primary care to improvements in many aspects of population and individual health are well-documented (Starfield, Shi and Macinko, 2005). The relationship between available and accessible primary care and decreased mortality among persons with low SES is particularly pronounced in the case of the African American population, thereby demonstrating that better primary care can reduce racial health disparities. According to research , person that report a regular source of primary care are more likely to receive appropriate care, fewer prescriptions, fewer diagnostic tests, and to experience decreased hospitalization and emergency care.

A survey conducted by the Atlanta Community Access Coalition asked residents in the three zip codes comprising the NPU-V if they had seen a physician in the past year. Over 75% of residents in the three zip codes report seeing the doctor, which is close to the percentage reported by adults in Fulton County (Figure 14). Given the high rates of uninsured in the NPU-V, these statistics may not accurately reflect the access to regular medical care and should be evaluated carefully.

Figure 14



Source: Atlanta Community Access Coalition; 2002

3. *Maternal and Child Health Indicators*

Maternal and child health indicators are central to understanding the needs of pregnant women and young children as evidence supports that birth outcomes influence the health and well-being of children as they develop and grow.

According to Collins et al. (2009), African American women that reside in urban neighborhoods with high concentrations of poverty and high rates of violent crime have increased rates of infant mortality and low birth weight babies. The considerable African American population in the NPU-V, along with the socio-demographic indicators presented previously, most likely contributes to the poor birth outcomes of NPU-V children.

Table 4 summarizes the 2000-2006 birth data for the NPU-V, Atlanta, Fulton County and Georgia. Between 2000 and 2002, there was an average of 310 births in the NPU-V.

Table 4

Birth Statistics				
	NPU-V	**Atlanta**	**Fulton County**	**Georgia**
Average Number of Births per year (2000-2002)	310	6574	13,261	150,804
Teen Birth Rate	8.70%	5.90%	4%	5.4%
Babies Born to Mothers with Less than 12 Years of Education (2006)	33.10%	24%	20.50%	24.30%
Number of Babies Born to Mothers who Smoke or Drink Alcohol during Pregnancy	26	385	623	
Less than 2 years between births (average 2000-2006)	23.90%			
% low birth weight babies	13.90%	11.40%	10%	9.80%
% Very low birth weight babies	4.60%			1.80%
% of Mothers Receiving First Trimester Prenatal Care	74.60%	79.10%	83.3	96%
Infant Mortality Rate (per 1,000 infants)	12.6*	8.7*	8*	8.4 (2004)

*Average IMR 2000-2006

Source: Healthy Start Births; Division of Population Health Fulton County

- Infant Mortality

Factors contributing to infant mortality are maternal health, public health practices, socioeconomic conditions, and availability and use of appropriate health care for infants and pregnant women. In the U.S., about two-thirds of infant deaths occur in the first month after birth and are due mostly to health problems of the infant, such as birth defects, or problems related to the pregnancy, such as preterm delivery (Hamilton, Martin and Ventura, 2009). Infant mortality has two long standing characteristics: it is very high in the U.S. compared to other developed nations, and the mortality rate for African Americans is more than twice that of Caucasians (Centers for Disease Control and Prevention, 2002). Currently the U.S. ranks 29th in the world in infant mortality rates, with almost 7 deaths per 1,000 infants (CDC, 2008). Georgia's infant mortality rate is the 7th highest in the nation. The risk factors associated with infant mortality include:

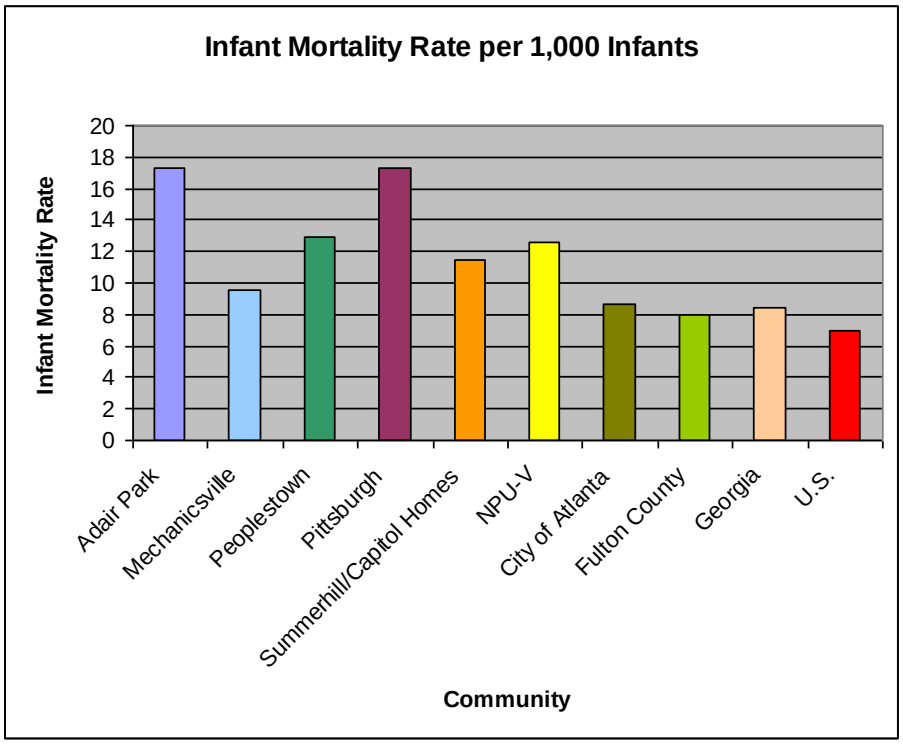
- Substance abuse, including alcohol, tobacco, and other drugs.
- Closely-spaced pregnancies.
- Maternal age extremes.
- Maternal experience of stressors such as poverty or experience of domestic violence.
- Inadequate prenatal care.
- Inadequate folic acid intake.
- Positioning babies on their stomachs to sleep (factor related to SIDS).
- Poor health and/or nutritional status of the mother.

- Some types of infections, such as reproductive tract infections and periodontal infections.
- Multiple births.

The Healthy People 2010 goal for infant mortality is 4.5 deaths per 1,000 infants. In 2004, Georgia's infant mortality rate was 8.4 deaths per 1,000 live births. Between 2001- 2006, the average infant mortality rate for the NPU-V was 12.6 per 1,000 live births (Figure 15).

Between 2000 and 2006, Adair Park and Pittsburgh had the highest average infant mortality rate at 17.3 deaths per 1,000 babies, followed by Peoplestown (12.9), Summerhill/ Capitol Homes (11.5) and the lowest, Mechanicsville (9.5). All of these rates are still more than double the Healthy People 2010 goal (Figure 15).

Figure 15



* NPU-V IMR are averaged between 2000-2006

Source: Healthy Start Births; Division of Population Health Fulton County

- Low Birth Weight

Research shows that babies born in poorer neighborhoods are more prone to be low birth weight or very low birth weight (Corn, Hamrung, Ellis, Kalb, & Sperber, 1995). Between 2005 and 2007, 13.9% of the babies born in the NPU-V were low birth weight babies, which is substantially higher than the Healthy People 2010 goal of 5%. The percentage of very low birth weight babies was not recorded for all of the NPU-V between 2005 and 2007, but for the five census tracts where it was recorded, an average of 4.6% of the babies born were very low birth weight babies. In addition to low birth weight, pre-term babies are at a much greater risk of neonatal mortality and morbidity. Between 2005 and 2007, 165 of the babies born in the NPU-V were born pre-term.

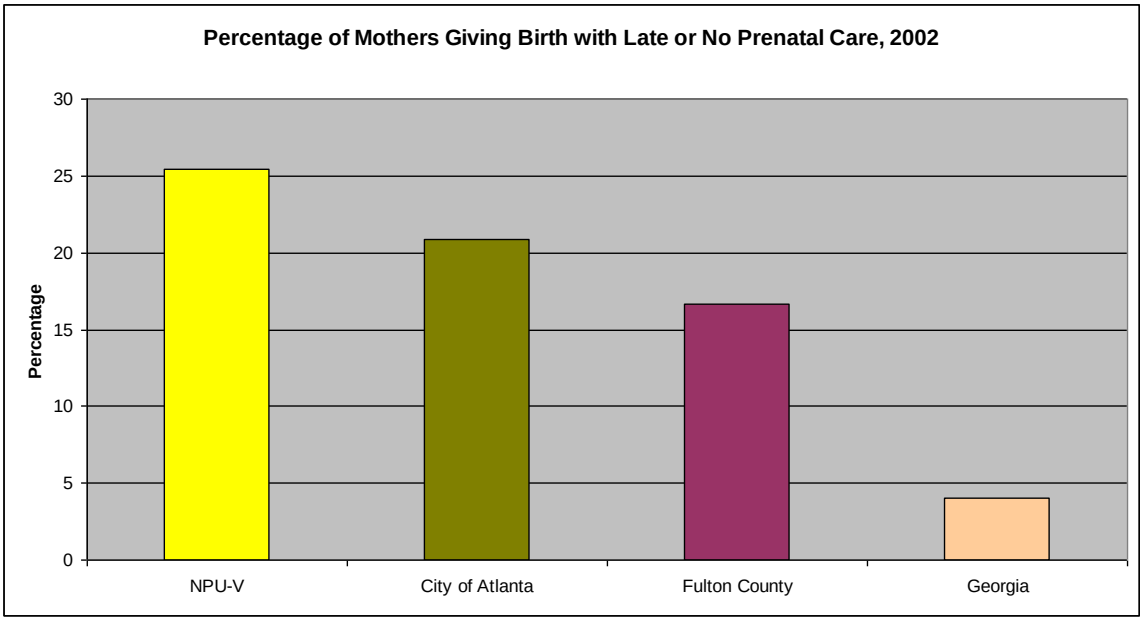
- Prenatal Care

A general consensus exists among practitioners that early and regular prenatal care by a healthcare provider can improve maternal and infant birth outcomes. Babies that do not receive adequate prenatal care may be at risk for a variety of adverse outcomes such as:

  - Stillbirth.
  - Early neonatal mortality.
  - Low birth weight.
  - SIDS.

In 2002, the percentage of babies born to mothers who received late or no prenatal care in the NPU-V was 25.4%, compared to 20.9% of mothers in Atlanta and 16.7% in Fulton County (Figure 16).

Figure 16



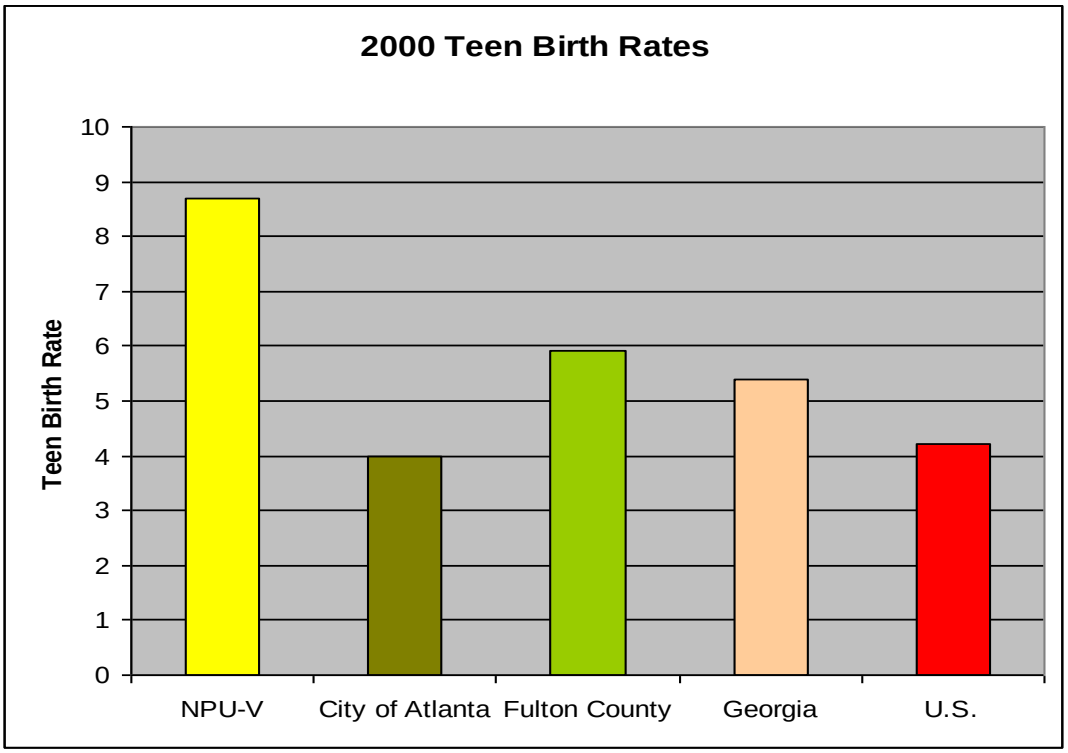
Source: Healthy Start Births; Division of Population Health Fulton County

- Teen Birth Rates

Adolescents who live in poverty are more likely than those with higher family incomes to engage in high risk behaviors such as early sexual activity (America's Children in Brief: Key National Indicators of Well-Being, 2008). Infants of teen mothers are more likely to face adverse health outcomes, including low birth weight, pre-term birth and infant mortality. According to a 1997 report by the National Campaign to Prevent Teen Pregnancy, children of teen mothers suffer educationally, performing worse than their peers on standardized tests, repeat grades more often, and drop out of school at a higher rate. Moreover, teen mothers are more likely to be unmarried, high school drop-outs, uninsured and living in poverty. Their children are also more likely to live in poverty.

The teen birth rate in the NPU-V in 2000 was 8.7%, substantially higher than Fulton County, Atlanta, Georgia and the U.S. (Figure 17). A recent report from the Centers for Disease Control (CDC) shows that the teen pregnancy rate in the U.S. rose between 2006 and 2007, ending a downward trend from 1991 to 2005. The study showed that one third of U.S. adolescents report having no birth control instruction before the age of eighteen.

Figure 17



Source: Healthy Start Births; Division of Population Health Fulton County

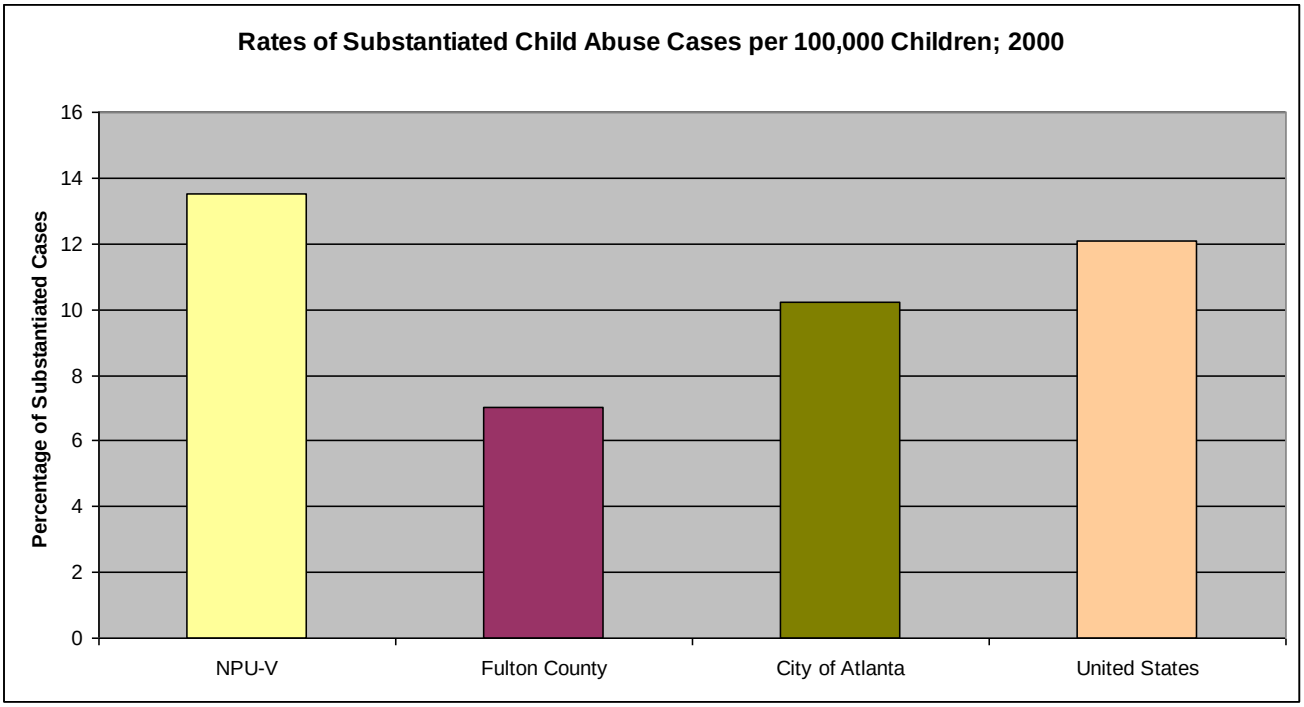
4. *Domestic Violence and Child Abuse*

Domestic violence and child neglect and abuse are a threat to the health and well-being of children and their families. Childhood maltreatment may have an effect on adult health as a result of biological and psychosocial factors (Chartier, Walker & Naimark, 2009). Researchers have reported that abused children have higher rates of medical problems, poor self-reported health, pain symptoms and functional disability (Chartier, Walker & Naimark, 2009). Based on self-report, women with incomes of less than $20,000 per year were six times more likely to have experienced domestic violence than women with incomes of more than $49,000 (America's Children in Brief: Key National Indicators of Well-Being, 2008).

Domestic violence is an issue in the NPU-V with increasing numbers of cases occurring over the last two years. The zip code 30315 in NPU-V is one of the highest ranked zip codes in Fulton County for domestic violence reports.

According to Prevent Child Abuse Georgia, the substantiated rate of child abuse in Georgia has risen by more than 50 percent between 2000 and 2006. The rate of substantiated child abuse and neglect cases in NPU-V is 13.5 cases per 1,000 children (Figure 18). This is almost double the rate of Fulton County, which is 7 cases per 1,000 children and higher than the Atlanta rate of 10.2 cases per 1,000 children (Figure 18).

Figure 18



Source: Healthy Start Births; Division of Population Health Fulton County

5. *Asthma*

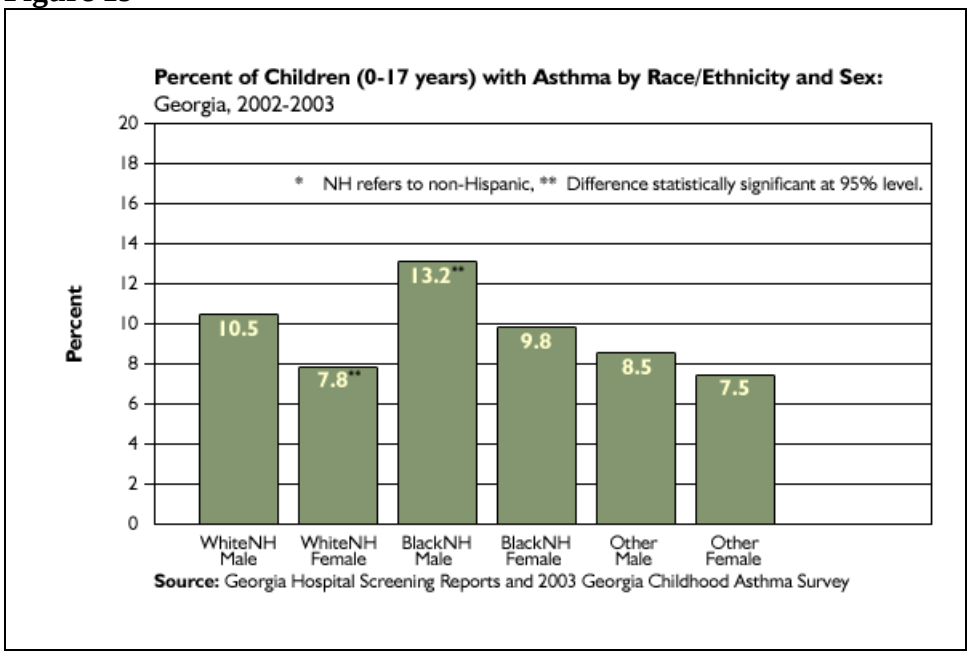
Asthma is a leading childhood chronic illness in the U.S. and places a large burden on affected children and their families (Akinbami and Schoendorf, 2002). Childhood asthma is associated with increased rates of doctor visits, hospitalizations, school absenteeism, parental work absenteeism, child activity limitations and child disability (Akinbami and Schoendorf, 2002). While it is true that there are racial disparities in asthma prevalence, much larger disparities exist in morbidity and mortality. Risk of asthma hospitalization and mortality has been found to be correlated with minority race and living in poverty (Nepomnyaschy & Reichman, 2006). Although most children living in poverty should have access to a source of asthma care, poor and minority children are less likely to receive high quality continuing care (Nepomnyaschy & Reichman, 2006).

According to the 2003 Georgia Childhood Asthma Survey, 2003, it is estimated that 212,000 children in Georgia under the age of 17 have asthma and it is the leading cause of school absenteeism in the state. The overall rate of emergency department visits due to asthma was 549 per 100,000 persons in Georgia in 2005. More than 50,000 emergency department visits for asthma occurred in Georgia in 2005.

Atlanta has been nicknamed the "asthma capital" of the nation by the Respiratory and Allergy Association. Fulton County has the highest asthma rate in Georgia, when measured by hospital discharge rates especially when stratified by race. In Fulton County (2001), 15.8% of public middle school children had asthma and there were approximately 1,200 hospitalizations for asthma in Fulton County in1999-2000. Mirroring the U.S.,

rates of asthma in Georgia and Fulton County are disproportionately higher for African American children (Figure 19).

Figure 19



According to the 2003 Georgia Childhood Asthma Survey, 2003, children between 5-12 years of age had the highest rates of asthma. Children ages 1-4 have the highest rates of asthma-related emergency department visits (Georgia Department of Human Resources, Division of Public Health, 2005). The burden of asthma is higher in children then any other population.

The children living in the NPU-V are most often living in poverty and therefore are at high risk for asthma. In order to improve health outcomes and academic achievement it is necessary to ensure they have access to high- quality continued asthma care.

6. *Immunizations*

In Georgia the rate of fully vaccinated children remained stable in 2006 (77%) and 2007 (78%), however, these rates were still below the Healthy People 2010 goal of 90%. According to the Georgia Immunization Study, 2007 conducted by the Georgia Department of Human Resources, Division of Public Health, Epidemiology Section, Immunization Program and Public Health Districts, a disparity of fully immunized two-year olds was seen among the 19 health districts of Georgia, ranging from 59% in the Fulton District to 98% in the East Central (Augusta) District.

Additionally, the children of mothers who were Medicaid recipients in Georgia were slightly less likely to be fully immunized at two years of age according to the 2007 Georgia Immunization Study.

Although neighborhood level data is not currently available, interviews with health providers in the NPU-V schools and health department indicate that immunizations are an issue, and most likely mirror or are worse than the statistics of the Fulton District. According to these providers, large numbers of children in the NPU-V are entering school not fully immunized, which would be consistent with the low rates of fully immunized two-year olds seen in the Fulton District.

7. *Mental Illness*

Low-income children, youth, and their families are disproportionately effected by mental health challenges, impairing the ability of children and youth to succeed in school and placing them at risk of involvement with child welfare and juvenile justice agencies (Schwartz, 2009). According to the project Accountable Communities: Healthy Together, conducted by Georgia State University Institute of Public Health in January 2008, the number one health concern of the residents of the NPU-V was mental illness. The NPU-V residents expressed concerns about mental illness ranging from mild depression to severe psychiatric disorders such as bipolar and schizophrenia. According to NPU-V residents, a significant barrier to care for mental illness is the stigma surrounding mental health in the African American community. According to the Fulton County Mental Health Needs Assessment for 2006:

- 20,999 adults in Fulton County were in need of addictive disease services from the public sector and 22.6 percent received treatment.
- 11,381 adults were in need of mental illness treatment from the public sector.
- 8,870 youth between 9-17 years of age were diagnosed with severe emotional disturbance (SED) and 19.2% were served.

8. *Substance Abuse*

Risk factors associated with parental substance abuse include poverty, family dysfunction, family violence and mental illness (Nair et al., 2007). Infants and toddlers with substance abusing parents are at an increased risk for receiving substitute care due to neglect/abuse or their mother's inability to care for them (Nair et al., 2007). A high prevalence of parental substance abuse has been reported in studies of children referred to child protective services for foster care placement due to neglect/abuse (Nair et al., 2007)..

Although community level data is unavailable, the Georgia Telephone Household Survey of Substance Abuse Treatment Need prepared for the Georgia Department of Human Resources by The Emory School of Medicine and the Gallup Organization (1998) reported:

- More than 186,000 adults and 17,000 adolescents in Georgia have significant problems resulting from alcohol and/or drug use.

- The prevalence of substance abuse is generally higher in males than females.
- The prevalence of substance abuse is generally higher in Caucasians than African-Americans.
- The percentage of adolescents using any substance other than alcohol and cocaine is higher than the percentage of adults using those substances.
- 20.9% of adults and 15.3% of adolescents who need treatment reported ever having received it.
- Slightly more than 75% of people needing services require intensive outpatient services, but approximately 18% of people needing services would require inpatient services.

Although neighborhood level data on the prevalence and use of substance abuse there is one substance abuse treatment program. However, there are several indicators within the community that substance abuse is a growing issue. The rate of substantiated child neglect/abuse cases in 2003 in the NPU-V was 13.5/1000 children. This is higher than the Atlanta rate of 10.2/1,000 children and the Fulton County rate of 7/1,000 children (Neighborhoods Count, 2004).

9. *Overweight and Obesity*

According to Education Vital Signs, 2006, being overweight and obese are independent risk factors for increased morbidity and mortality throughout the life cycle. Overweight and obesity in children is now an epidemic in the U.S. In 2004, CDC published a report on a research study conducted from 1999 to 2002 entitled "Prevalence of Overweight and Obesity among Children and Adolescents in the U.S. According to that report, 16 % of children (over 9 million), 6-19 year olds are overweight or obese which is three times what it was in 1980. The Healthy People 2010 goal is to have a 15% obesity rate for adults age 20 and older. In 2005, Georgia reported:

- 27% of young children 2 to<5 years are overweight or at risk for overweight.
- 33% of middle school and 26% of high school students are overweight are at risk for overweight.
- 59% of adults, 18 years and older are overweight or obese.
- Georgia ranks 14th in the United States for adult obesity.
- Georgia has the 13th highest inactivity rate at 25.9 percent.
- Approximately 10 percent (6,700) of Georgians die from obesity each year.
- Georgia is in the top 15 states for the highest obesity rates for youths ages 10 through 17.

According to this same study, obesity has "more than doubled" in both children and adolescents from ages 2-5 and also ages 12-19, while more than tripling in children between the ages of 6-11. Although neighborhood level data is not available, the CDC Chronic Disease indicator reports:

- The prevalence of obesity among adults aged 18 and older in Georgia is 28.7% slightly higher than the U.S. rate of 26.3%.

- The prevalence of obesity among youth less than 18 years of age in Georgia is 13.8% only slightly higher than the U.S. rate of 13%.
- The prevalence rate of the youth in Georgia attaining the recommended level of physical activity was 43.8% while the rates for the U.S. lagged behind at 34.7%.

10**.** *Adult Health*

As stated earlier in this report approximately 40% of adults in the NPU-V had no health insurance in 2002, a number significantly higher than the U.S. While residents reported seeing the doctor on a regular basis, as indicated previously, the high rates of uninsured would seemingly not correspond to the survey results.

As would be expected in a community comprised of significant minority adults, chronic and preventable diseases are highly prevalent. The Southside Health Center in the NPU-V reports the top diagnosis for adults in the NPU-V in 2004-2005 was hypertension. Approximately, 39 percent of adult residents of the NPU-V self report having been diagnosed with hypertension.

The second most common reported adult diagnosis of the Southside Health Center for NPU-V residents is diabetes. Approximately 18 percent of adult residents of the NPU-V self report having been diagnosed with diabetes which is surprisingly lower than in Fulton County. The prevalence of diabetes in the NPU-V is 48% higher than it was a decade ago (Georgia State University, 2008). There are additional high rates of heart disease and cancer self- reported by the residents of the NPU-V.

Additional diagnoses mentioned in the top 10 by Southside Health Center are acute URI (males), eye disorders, teeth disorders, atopic dermatitis and asthma. Neither mental health nor depression is mentioned by the Health Center.

IV. Neighborhood Profile Socio-Demographic Summary

The above data provides important demographic information about the NPU-V that must be incorporated into the planning for the health strategy by the Atlanta Civic Site. Based on the demographic and health data reviewed above, the following is a summary of the major findings that are critical to address as the health planning moves forward:

1. **Children comprise a significant segment of the NPU-V population and approximately one in five children are under the age of five.** The population of the NPU-V consists of 35 percent children under the age of eighteen which is significantly higher than Atlanta at 22 percent. Approximately 18 percent of the children are under the age of five. Focusing on children in the younger years can have significant return on investment in improved health and educational outcomes later in childhood and adulthood.
2. **The NPU-V is comprised of a racially homogenous population, approximately 92 percent of the residents are African American**. Therefore the cultural views and ideology must be taken into account when planning for health and healthcare programs in the NPU-V. Recognition of the health disparities impacting the African American population will be critical to address the priority needs of the adult parents of children in the NPU-V.
3. **Children and families living in the NPU-V are extremely poor contributing to challenges in accessing health care and disparities in health status.** In the NPU-V, 42.8% of families live below the federal poverty line. This is almost four times the number in Fulton County. This figure is even higher when looking at the percentage of children living below the federal poverty line. Additionally, Summerhill/Capital Homes and Mechanicsville have twice the number of children living in poverty compared to the other NPU-V neighborhoods.
4. **Significant numbers of NPU-V children are living in single parent families which place them at higher risk for abuse, neglect and increased stress contributing to higher rates of childhood illness.** The NPU-V has more than double the percentage of single parent families as Fulton County.
5. **High rates of high school drop-out and low educational attainment create additional challenges to parenting and employment which place children and parents at higher risk for preventable illnesses.** The educational level of residents of the NPU-V is very low when compared to Atlanta, Fulton County, and Georgia. This indicates that many parents in the NPU-V may struggle to find employment and thus contributes to the above cited poverty levels. Parents with educational levels below a high school diploma can pose barriers to parent(s) understanding fundamental health and developmental needs of their children which is critical to successful growth, development and learning.
6. **Many NPU-V parents and children live in unhealthy housing as well as a decaying physical environment which impacts healthy growth and contributes to mental illness, asthma and obesity.** The aging and changing housing profile of the NPU-V negatively contributes to the physical and

mental health of residents. Communities with large numbers of vacant and dilapidated houses have increased health risks such as lead exposure, mental health disorders, electrical hazards and exposure to pollutants such as rodents, mold and dust mites.

V. Neighborhood Profile Health Indicator Summary

The following is a summary of the major findings from the analysis of health indicators:

1. **Health insurance coverage and therefore access to health care is a major issue for adults and children.** Approximately one third of the adult residents in the NPU-V are uninsured. This is almost two times the rate of the U.S. Therefore significant number of parents could be suffering from chronic and debilitating physical and mental health issues that prevent them from focusing on the needs of their children. In the NPU-V, almost 50 percent of the children in each zip code are uninsured. This leaves them with no access to a regular source of health care. Given that there are very few undocumented children, income levels support that the majority of these children should be qualified for some public benefits such as Medicaid and Peachcare.
2. **Children born in the NPU-V are at a significant risk of less than optimal growth and development and/or death due to high rates of infant mortality, low birth weight, teen pregnancy and late or no prenatal care.** These poor birth outcomes compromise children's ability to have the best start possible for future health and educational achievement:
    - Infant mortality is a significant issue in the NPU-V. The rate of infant mortality is three times higher than the Healthy People 2010 goal of 4.5 deaths per 1,000 babies born. The Adair Park and Pittsburgh rate of 17.3 deaths per 100,000 babies born is comparable to rates in developing countries such as Sri Lanka at 17.5 deaths per 100,000 babies born.
    - Mothers in the NPU-V are not receiving prenatal care in the first trimester of pregnancy and many are not receiving any prenatal care at all.
    - The rate of low birth rate babies being born in the NPU-V is almost three times the Healthy People 2010 goal of 5%.
- Teen birth rates had been declining in the U.S. for many years but have recently turned around and are again on the rise. Following this national trend, teen birth rates in the NPU-V are on the rise and are currently two times higher than the Healthy People 2010 goal.

3. **High rates of asthma in NPU-V children hinder healthy development and impact academic achievement.** Chronic illnesses such as asthma are prevalent in the NPU-V. Asthma is a significant health risk for children. The rates are so high that Atlanta has been nicknamed the "Asthma capital of the Nation." Asthma is a leading cause of emergency department visits, hospitalizations and school absenteeism and therefore must be considered when addressing strategies to maximizing children's health and school attendance.

4. **Overweight and obesity is an issue in the NPU-V for adults and children**. This is significant because it leads to additional chronic and debilitating diseases such as diabetes, hypertension and heart disease.
5. **Mental illness is the number one issue cited by residents**. While there is very limited quantitative data to document this issue, interviews with residents consistently indicate that mental heath needs are an extremely high priority for NPU-V children and their parents. The high rates of poverty, social isolation and poor neighborhood conditions are situational factors that contribute to the many reports of depression and other more serious mental illnesses afflicting the community.
6. **NPU-V children are at high risk for neglect and abuse.** The rates of child abuse and neglect are extremely high in the NPU-V, higher than in the county and state.
7. **Parents of children in the NPU-V suffer from high rates of chronic preventable conditions which impact their ability to care for their children.** The chronic diseases suffered by adults in the NPU-V, such as, diabetes, hypertension, respiratory illnesses and heart disease, mimic those suffered by adults in the U.S.

VI. Inventory and Profile of Services and Providers

A. Overview of Public Health System

The public health system is important because it educates and treats individuals regarding prevention and addresses the need to eliminate disparities by easing access to preventive services for those less able to use existing health services. It ensures the availability of primary care through direct funding of clinics and providers.

In the state of Georgia, there are three state agencies, each with several departments and divisions that oversee various aspects of public health for the state. These agencies are: (1) Department of Human Services (DHS), which was recently renamed from the Department of Human Resources, (2) Department of Community Health (DCH) and (3) Department of Behavioral Health and Developmental Disabilities. The public health model in Georgia is somewhat fragmented, with the three agencies often working in parallel, creating challenges to sharing data and resources.

On July 1, 2009, the three state agencies underwent a reorganization, which may decrease the degree of fragmentation given that certain important functions related to health care coverage and public health services are now combined in the same state agency, Department of Community Health. However, eligibility for health insurance still remains in the Department of Human Services continuing to contribute to difficulties in coordinating outreach and enrollment for health insurance.

The mission of the DHS is to provide residents of the state of Georgia with human services that promote child and adult protection, child welfare and self-sufficiency. The divisions/offices within DHS are the following:

- Division of Aging Services (DAS), which coordinates with other aging organizations to provide services to appropriately sustain older Georgians in their homes and communities. These services also provide support to family members and caregivers. The services provided include home-based support, nutrition and wellness, caregiver programs and Medicare and insurance programs.
- Office of Child Support Services (OCSS) enforces parental responsibility to pay financial support.
- Division of Family and Child Services (DFCS) is responsible for welfare and employment support, protecting children, foster care and other services to strengthen families.

The second state agency is the Georgia Department of Community Health which serves as the lead agency for health care planning and purchasing services in Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. DCH is also designated as the single state agency for Medicaid. The divisions within DCH are:

- Public Health (DPH), which has the responsibility for the delivery of public health services to communities. At the state level, DPH is divided into numerous branches, sections, programs and offices, and at the local level, DPH functions via 18 health districts and 159 county health departments.
- Medicaid and PeachCare divisions- Oversee and manage the Medicaid and PeachCare for kids programs. Medicaid is the public insurance benefits provided to the highest need residents of Georgia. PeachCare for Kids is the state children's health insurance program (S-CHIP).
- Emergency Preparedness (EP) has the responsibility to operate the state's Health Alert Network (HAN) in conjunction with the CDC and provide services such as drought response guidance, emergency medical services, health alerts, and individual and family preparedness.
- Office of Regulatory Services (ORS) inspects, monitors, licenses, registers and certifies a variety of health care, long-term care and residential child care facilities.

The third agency is the Department of Behavioral Health and Developmental Disabilities (DBHDD) which in the July reorganization moved out from under the umbrella of the Department of Human Resources. DBHDD provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. Services are offered through a regional system with planning and oversight by regional offices. Agencies and offices include the following:

- Adult Mental Health.
- Child and Adolescent Mental Health Services.
- Addictive Disease.
- Developmental Disabilities.

- Various Support Services.

Fulton County is the local health jurisdiction that provides public health services to the residents of the NPU-V. While most county public health departments around the country have discontinued the delivery of primary care, Fulton County Department of Health and Wellness continues to deliver primary care services through a variety of health clinics and agencies. There are 12 health centers operated by the Department and seven are located in Atlanta.

Services delivered by the Fulton County Department of Health & Wellness include:

- Women's health services.
- Tuberculosis screening and prevention.
- Sexually transmitted infections and HIV prevention and treatment.
- Vital records services.
- Immunizations.
- Mobile health vans.
- WIC programs.
- Breastfeeding education programs.
- Public Health nursing outreach, assessment, referral and case management for high risk families.
- Adolescent health and youth development.
- Children and adult dental care.

The Common Ground initiative is Fulton County Department of Health and Wellness' newest program to address health disparities in the community. The initiative has been implemented with the goal of creating equity through public policy and community engagement. Common Ground's approach is aimed at addressing the numerous social determinants contributing to health for Fulton County residents. The primary vehicle for service delivery is the creation of "one stop" health and human service centers that co-locate numerous public health services with other critical human services to increase comprehensiveness and accessibility.

The first Common Ground center is the Neighborhood Union Health Center. The health center opened in February, 2009 with a focus on providing services that address the entire well-being of the person. Clients at the Neighborhood Union Health Center have centralized access to health care, behavioral health and substance abuse services, job counseling and training.

The second Common Ground initiative, called Primary Care Lite, provides affordable and limited primary care services to uninsured adults in Fulton County with a focus on education, prevention and health screenings. The cost for initial/follow-up visits and lab services is $20.00 or based on a sliding scale fee.

B. Access to Health Insurance and Medicaid

1. Children's Health Insurance and Medicaid

Health insurance coverage is available in Georgia for poor families with children through Medicaid and PeachCare for Kids. According to Hughes and Ng (2009), expanded health insurance eligibility is the first step in improving the health outcomes for low income children and their families.

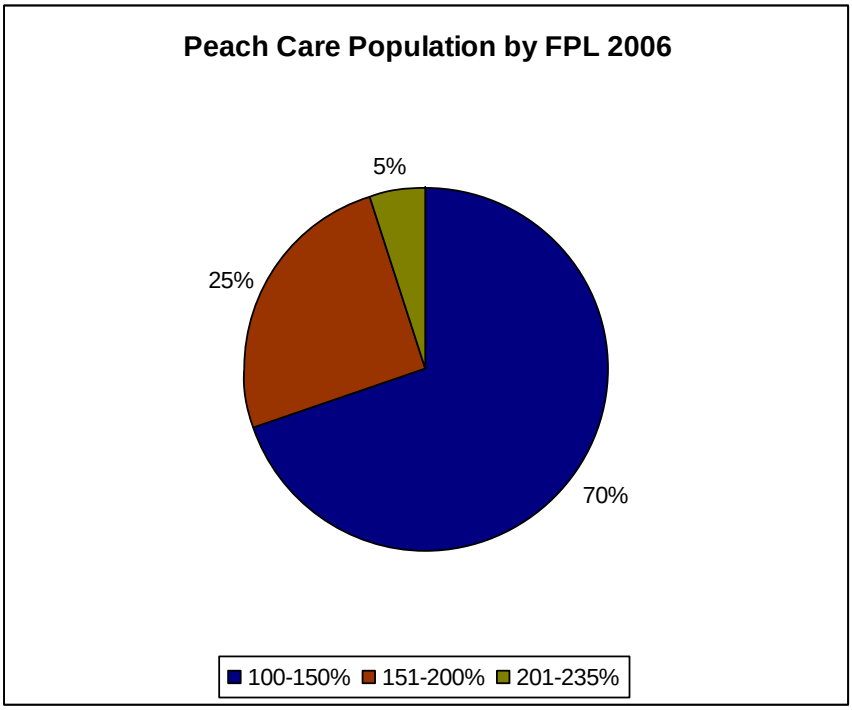
- Peach Care for Kids

In 1997, Congress created Title XXI of the Social Security Act to provide health care for the growing number of uninsured children in the U.S. This legislation gave states an opportunity to create State Children's Health Insurance Programs (S-CHIP). In February, 2009, Congress passed a $33 billion bill to expand the S-CHIP program. The bill is expected to provide government subsidized health insurance to approximately four million additional children in the U.S.

PeachCare for Kids (PCK) is Georgia's State Children's Health Insurance Program (SCHIP) that provides low-cost health care coverage to children up to age eighteen. PeachCare for Kids is a comprehensive health care program for uninsured children living in Georgia. The health benefits include primary, preventive, specialist, behavioral health, dental and vision care. Each child in the program has a Georgia Families Care Management Organization that is responsible for coordinating the child's care. There are currently three Managed Care Organizations (MCOs) participating: Amerigroup, Peach State and Well-Care. Currently, approximately 204,000 children in Georgia are enrolled in PeachCare and 11,637 in Fulton County. The program is administered by the Georgia Department of Community Health. The current projection is that an additional 40,000 children in Georgia will be enrolled in PeachCare by the end of 2010.

Eligibility: Children must be citizens of the U.S. or legally residing in the U.S. for at least five years. Citizenship applies only to the child. Children must be residents of the state of Georgia. PCK requires documentation of citizenship of the child and income verification of the household. Children in a family with an income below 235 percent of the federal poverty level can qualify. Income level is reviewed annually as part of the renewal process (Figure 20).

Figure 20



Children enrolled in PeachCare are eligible to receive the following services**:**

- Preventive services such as immunizations and regular check-ups.
- Doctor visits.
- Specialist care.
- Dental care.
- Vision care, including screenings and glasses.
- Hospitalization.
- Emergency room services.
- Prescription medications.
- Mental health care.

Applying for PeachCare for Kids: Applicants for PeachCare complete a dual Medicaid/ PeachCare application and program eligibility is determined during processing. Applicants can apply for PeachCare online or by mail. When the application is received, the applicant is reviewed for PeachCare and Medicaid eligibility. The applicant is notified by mail of the status. There are no office-based enrollment services available, therefore families need to have access to a computer and the application available to complete and then mail in order to apply.

Peach Care for Kids Community Outreach: Right from the Start (RSM) is a Medicaid unit that is specifically contracted to improve health outcomes for children and pregnant women. In 2008, RSM staff made 81,464 referrals for Peach Care for Kids. There are no RSM outreach workers stationed in NPU-V.

- Medicaid

As the largest division in Community Health, the state administers the Medicaid program, which provides health care for low income children, pregnant women, and people who are aging, blind and disabled. It is available for children up to age nineteen.

The organization of the Medicaid program is the same as PeachCare, with each family having a choice from the three MCO's listed above. The benefits for Medicaid recipients are the same as those listed above for PeachCare.

Eligibility: The citizenship and residency eligibility requirements for Medicaid are the same as those listed above for PeachCare. Children are eligible for the different types of Medicaid programs according to their family income, as shown in table 5 below:

Table 5

Low-Income Medicaid (LIM) Adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.	
Family Size	**Income Limits**
1	$235 per month ($2,820 per year)
2	$356 per month ($4,272 per year)
3	$424 per month ($5,088 per year)
4	$500 per month ($6,000 per year)
Right from the Start Medicaid for Pregnant Women and their Infants (RSM Adults and Newborns) Pregnant women and their infants with family income at or below **200%** of the federal poverty level.	
Family Size	**Income Limits**
1	$1,805 per month ($21,660 per year)
2	$2,429 per month ($29,148 per year)
3	$3,052 per month ($36,624 per year)
4	$3,675 per month ($44,100 per year)
Each additional person: $624 per month ($7,488 per year)	
Right from the Start Medicaid (RSM Children) - 185 % FPL Children under 1 whose family income is at or below **185%** of the federal poverty level.	
Family Size	**Income Limits**
1	$1,670 per month ($20,040 per year)
2	$2,247 per month ($26,964 per year)
3	$2,823 per month ($33,876 per year)
4	$3,400 per month ($40,800 per year)

Each additional family member: $578 per month ($6,936 per year)	
Right from the Start Medicaid (RSM Children) - 133% FPL Children 1 to 5 whose family income is at or below **133%** of the federal poverty level.	
Family Size	**Income Limits**
1	$1,201 per month ($14,412 per year)
2	$1,615 per month ($19,380 per year)
3	$2,030 per month ($24,360 per year)
4	$2,444 per month ($29,328 per year)
Each additional family member; $415 per month ($4,980 per year)	
Right from the Start Medicaid (RSM Children) - 100% FPL Children 6 to 19 whose family income is at or below **100%** of the federal poverty level.	
Family Size	**Income Limits**
1	$903 per month ($10,836 per year)
2	$1,215 per month ($14,580 per year)
3	$1,526 per month ($18,312 per year)
4	$1,838 per month ($22,056 per year)
Each additional family member; $312 per month ($3,744 per year)	

Applying for Medicaid: Applicants for Medicaid complete the same dual Medicaid/ PeachCare application and program eligibility is determined during processing. To apply for Medicaid, you must submit a completed application at any local DFCS office, by mail, telephone, fax, e-mail, or at designated agencies. When the application is received, the applicant is reviewed for both PeachCare and Medicaid eligibility. The applicant is notified by mail of eligibility.

Medicaid Community Outreach: The community outreach for Medicaid is conducted by the same Right from the Start (RSM) workers outreach for PeachCare for Kids.

- Right from the Start Medicaid

Right from the Start Medicaid (RSM) is a type of Medicaid program designed to increase coverage for low and moderate income pregnant women. RSM pays for medical care for pregnant women, including labor and delivery, for up to 60 days after they give birth. Pregnant women who qualify are entitled to the full-range coverage of Medicaid services that are listed above.

Eligibility: Pregnant women may qualify if their monthly income does not exceed 200 percent of the federal poverty level limit as shown in the chart above. A pregnant woman is counted as two people in the calculation of family size, helping to increase eligibility. In addition, a woman meeting the income standards may become eligible within 60 days after giving birth, even if she did not apply during pregnancy or delivery. Infants born to

women receiving Medicaid on the day the child is born receive Medicaid until they reach their first birthday. Children up to age 19 may qualify at various income levels depending upon age and family size. Children up to age one may qualify if their family income is at or below 185 percent of the federal poverty level limit; age one to five if their family income is at or below 133 percent of the federal poverty level limit; and age six to nineteen if their family income is at or below 100 percent of the federal poverty level limit.

Applying for Right from the Start Medicaid: The application process for RSM is the same as the application process for Medicaid, as explained above.

Right from the Start Medicaid Community Outreach: The community outreach is completed by the same RSM outreach workers listed above. The MCO, Amerigroup has been attempting to increase the number of pregnant women receiving prenatal care and has had outreach workers walking the streets in Fulton County looking for pregnant women to enroll.

- Outreach and Enrollment

As indicated in the previous neighborhood profile section of the health scan, approximately 50% of children residing in each of the three zip codes encompassing the NPU-V are uninsured. Given the income levels of NPU-V families, it is reasonable to assume that a large majority of the children are eligible for Medicaid or PeachCare and are not enrolled due to difficulty with the enrollment process.

When SCHIP was initially implemented nationally, Georgia ranked 4th in the country in its enrollment of eligible children. Due to their efforts and subsequent budget shortfalls, the Governor passed legislation that enacted a cut-off in enrollment to PeachCare for Kids in 2007. This had a significant impact in reducing the number of children who could receive coverage and eliminated the outreach and enrollment staff that had previously provided support and assistance in communities like the NPU-V.

With President Obama's expansion of the SCHIP funding in early 2009, Georgia has once again reinstated access to PeachCare for eligible children without a cut-off. However, the availability of outreach staff in communities is still sorely lacking, although this may be changing with recent grant proposals through the Federal Stimulus funding available to states to increase outreach for SCHIP.

As indicated above, the Division of Family and Children Services has a contracted unit, Right from the Start, which is charged with the mission of improving health outcomes for children and pregnant women. In 2008, Right for the Start made 81,464 referrals for PeachCare for Kids. This unit also recently expanded the availability of outreach staff to assist in enrollment in a number of community sites across Fulton County. However, not one of the 125 Right from the Start community outreach workers is stationed within the NPU-V. There are six Right from the Start offices located in Fulton County:

- RSM Project Office
  2300 Henderson Mill Rd
  STE 421
  Atlanta, GA 30345

- Morehouse Family Health Center
  513 E. Cleveland Avenue
  East Point, GA 30334

- Willie Freeman Clinic
  1920 John Wesley
  College Park, GA 30337

- South Fulton Medical Center
  1170 Cleveland Avenue
  East Point, GA 30344

- Scottish Rite Hospital
  1001 Johnson Ferry Road
  Atlanta, GA 30342

- Life Cycle OB/GYN
  1100 Cleveland Avenue
  East Point, GA 30344

At this time, the only assistance available to families for enrollment in the NPU-V is through the Center for Working Families and South Side Health Center. As part of the initial evaluation process, staff from the Center assess family eligibility for health insurance and assist families with the application process for Medicaid or PeachCare. While this is a very important service, there remain large numbers of families and children that could be enrolled in health insurance but lack the assistance necessary to help with a complicated application process. Additional barriers such as low education levels, lack of transportation and difficulty obtaining all necessary documentation only further prevent families in the NPU-V from enrolling in the health insurance that they and/or their children are eligible for.

C. Primary Health Care

Access to primary health care is perhaps one of the most important services necessary to assure that families with young children are healthy and prepared to succeed in school. There are many different settings where families can receive primary health services, including private doctor's offices, community health centers and mobile clinics. Access to primary health care for children is critical, as this is the setting in which they should receive screening and early detection for disease and disabilities (EPSDT). Beginning at birth, it is important for infants and children to visit a primary care provider according to the American Academy of Pediatrics' recommended schedule for preventive health visits.

During these scheduled visits, the pediatric provider should perform a comprehensive history and physical examination of the child to detect any illnesses, conduct developmental screening to identify potential delays, give immunizations as necessary and provide anticipatory guidance to parents on their child's growth and development. Those children who do not receive regular preventive well child care, are at risk for not having illnesses, developmental delays and other health problems identified and addressed.

There is a lack of accessible primary care in NPU-V due to numerous barriers to accessing services, such as lack of transportation, childcare, health insurance and primarily due to the lack of sufficient services in the neighborhood. Southside Health Center is the only health center located in the NPU-V, however their capacity is limited and residents cite payment for out of pocket costs as a major issue. The Center for Black Women's Wellness operates a part- time clinic; however their access is limited to approximately eight appointments per week. The West End Health Center is located outside the NPU-V and therefore many residents are unable to access services. As a result, most NPU-V families rely on the Grady Hospital emergency room as their primary source of health care.

1. Federally Supported Community Health Centers

A federally qualified health center (FQHC) is primary health care provider that receives federal funding from the Bureau of Primary Health Care. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. They are non-profit organizations governed by a board of directors comprised of over 50% consumers of the health center. This aspect of FQHC governance is designed to assure that the centers are responsive to the health needs of their target communities.

FQHC's are located in federally approved health professional shortage areas that demonstrate a population that is medically underserved. They receive federal funding to provide comprehensive services including pediatric, ob/gyn, well women, adult care, mental health and dental services. Their mission was originally started in the 1960's as part of the War on Poverty to provide neighborhood- based health care for poor families, including those without health insurance. FQHC's continue to operate using a sliding fee scale and provide services to the poor and uninsured patients. There are currently 27 FQHC's in Georgia. There is only one center in the NPU-V and one directly outside the neighborhood. The following is a listing of the neighborhood FQHC's that provides services to NPU-V families:

- Southside Health Center (Not on a Marta Line).
  1046 Ridge Avenue, S.W.
  Atlanta, GA 30315
  (404) 688-1350

  Hours of Operation:
  Monday through Friday 8 a.m. to 5 p.m.
  Saturday 9 a.m. to 2 p.m.
  Monday through Friday night clinic 5p.m. to 10 p.m

  Services available:

  - Women's health / family planning.
  - Adult medicine
  - OB/GYN.
  - Pediatrics and teen health.
  - STD services.
  - Auxiliary (labs, x-rays and transportation).
  - Dental care.
  - WIC services.
  - Substance abuse- Outpatient treatment services.
  - Optometry.

- West End Medical Center (on Marta line)
  868 York Avenue SW
  Atlanta, GA 30310
  (404) 752-1400

  Hours of Operation:
  Monday through Thursday 8 a.m. to 9 p.m.
  Friday 8 a.m. to 5 p.m.
  Saturday 9 a.m. to 1 p.m.

  Services available:

  - Adult medicine.
  - Women's health OB/GYN, family planning.
  - Dental care.
  - Pediatric care.

2. Health Department Clinics

- Lakewood Health Center
  1853 Jonesboro Road, SE
  Atlanta, GA 30315
  (404) 626-0626

  Hours of Operation:
  Monday through Friday 8:30 a.m. to 5 p.m.

  Services Available:

  - Pediatrics.
  - Dental services.
  - Eye, ear, lead, Tb and dental screening.
  - Family planning.
  - Women's health.
  - HIV screening.
  - Immunizations.
  - Perinatal case management.
  - Pregnancy test.
  - Presumptive Medicaid application.
  - STD screening and treatment.
  - WIC services.
  - Children 1st.

- The Center for Health and Rehabilitation (Not on the Marta line).
  265 Boulevard, NE.
  3rd Floor
  Atlanta, GA 30312
  (404) 730-5835

  Hours of Operation:
  Monday through Friday 8:30 a.m. to 5 p.m.
  2nd & 4th Tuesday 8:30 a.m. to 6p.m. (Late clinic).

  Services available:

  - Pediatrics.
  - Family planning.
  - Breast test & more (Breast and cervical cancer screening).
  - Women's health.
  - HIV screening.
  - Immunizations (children and adults).
  - Lead eye, ear, lead, Tb, HIV and dental screening.
  - Perinatal case management.

- Pregnancy test.
- Presumptive Medicaid application.
- STD screening and treatment.
- WIC services.
- Children 1st.
- Travel clinic.

- Aldredge Health Center
  99 Jesse Hill Jr. Drive, SE
  Atlanta, GA 30303
  (404) 730-1211

  Hours of Operation:
  Monday through Friday 8:30 a.m. to 5p.m.

  Services Available:

  - Dental services.
  - HIV screening and treatment.
  - Immunizations.
  - STD screening and treatment.
  - Tuberculosis screening.
  - WIC services (1 day a week).

- Neighborhood Union Health Center (On the Marta line).
  186 Sunset Avenue, NW
  Atlanta, GA 30314
  (404) 612-4665

  Hours of Operation:
  Monday through Friday 8:30 a.m. to 5 p.m.

  Services available:

  - Children 1st.
  - Communicable disease follow-up.
  - Ear, eye, dental screening.
  - Adult dental services.
  - Family Planning/women's health:
    - Blood pressure and weight evaluation.
    - Breast and pelvic exam, pap smear screening and referral (if needed).
    - Breast self exam instruction and counseling.
    - Screening, diagnosis, treatment and/or referral for vaginal infections, sexually transmitted infections, including HIV.
    - Routine laboratory testing.

    - Mammogram referral.
    - Pregnancy testing.
    - Referral for peri-natal and other case management services.
- HIV counseling and testing.
- Immunizations.
- Lead screening.
- Newborn metabolic disease screening.
- Perinatal Case Management (PCM).
- Adult medicine.
- Pediatrics.
- WIC services.
- Psychiatric evaluation and treatment.
- Mental health and substance abuse screening, assessment, and treatment planning.
- Parenting skills classes.

2. Private Physicians

Southside Health Center is the largest provider of healthcare services in the NPU-V. An exhaustive search of private physicians determined that there are none located within the NPU-V. There were a total of 21 private doctors located in the three zip codes that cross the NPU-V:

- Zip code 30312:
    - 2 pediatricians.
    - 5 family practice/internal medicine.
    - 2 dentists.
    - 1 OB/GYN

- Zip code 30315:
    - 10 family practice/internal medicine.

- Zip code 30310:
    - 1 podiatrist

3. Hospital Outpatient Clinics

- St. Joseph's Mercy Hospital Clinic

St. Joseph Mercy Hospital is a 410 bed acute care facility. St Joseph's Hospital provides primary healthcare, education and social services to thousands of Atlanta's undeserved population through the operation of four outpatient clinics in Atlanta. The St. Joseph Mercy Clinic is most likely to be used by the residents of the NPU-V and is located downtown.

- St Joseph Mercy Clinic- Downtown (King Memorial Marta Station)
  424 Decatur Street
  Atlanta, Georgia 30312

  Hours of Operation:
  Appointments are encouraged, but walk-ins are accepted.
  Monday through Friday 8:30 a. m. to 5 p.m.

  Services Available:

  - Adult medicine.
  - Pediatrics.
  - Immunizations.

- Grady Memorial Hospital Health Clinics

Grady Memorial Hospital is a 700 bed level one trauma center and the only public hospital in Atlanta. The major healthcare facility serving the NPU-V community, Grady operates eight community health centers in the area but none are located within the NPU-V. They also offer a primary care clinic at the downtown hospital location.
Grady hospital enjoys a rich tradition in Atlanta and in the NPU-V. The saying "Go to Grady" is used often when people are sick and do not have a primary care physician. Many families use Grady's emergency department for primary care.

Grady Hospital operates eight outpatient clinics in the Atlanta area, however only one is close enough to be used by the residents of the NPU-V:

- DeKalb Grady Health Center
  30 Warren Street, SE
  Atlanta, GA 30317
  (404) 616-9304

Hours of Operation:
Monday through Thursday 8 a.m. to 9 p.m.
Friday 8 a.m. to 5 p.m.
Saturday 9 a.m. to 1 p.m.

Services available:

- Pediatrics.
- Family planning.
- Primary care
- Nutrition counseling.
- Pharmacy

- Grady Hospital Primary Care Clinic
  80 Jesse Hill Drive, SE
  Atlanta, GA 30303
  (404) 615-1973

  Services available:

  - Primary care.
  - Pediatrics.
  - Family planning.
  - Women's health.
  - Pharmacy.
  - Immunizations

D. School Health Services

Providing health care services in schools for children is important to assure students stay as healthy as possible to maximize their opportunities for school success. A core set of services are mandated by the federal government to be provided to all students in schools, that include age appropriate health screenings, care to children with special health care needs and support to students with chronic illnesses. In addition, students in special education are required to have a health component, as part of their individualized education plans that are developed by the interdisciplinary team in the school.

There are six schools that serve the children of NPU-V:

- Gideons Elementary School – part-time nurse in school two half days each week.
- D.H. Stanton Elementary School – part-time nurse is in the school one day per week.
- Dunbar Elementary School- part-time nurse in school one day per week.
- Cook Elementary School- part-time nurse in school one day per week.

- Parks Middle School –Unknown.
- Carver High School (4 campuses) - No school nurse.

With the limited hours and days of nurse availability, the students in NPU-V are clearly not receiving adequate health services, which have implications for their ability to achieve at the highest levels.

E. Supportive Services for Pregnant Women and Families with Young Children

Services such as home visiting, developmental screening, WIC and parent education are important programs for pregnant women and young children to assure healthy birth and early child health outcomes.

1. WIC (Women, Infants and Children) Programs

The WIC Program is a national nutrition education program that promotes the availability of nutritious foods for pregnant women and families with young children. WIC serves as a safety-net for the health of low-income women, infants and children up to the age of five who are at nutritional risk. The Georgia WIC program is the seventh largest Special Supplemental Nutrition Program for Women, Infants and Children in the U.S. WIC provides the following services:

- Nutrition assessment.
- Health screening.
- Medical history.
- Body measurement (weight and height).
- Hemoglobin check.
- Nutrition education.
- Breast-feeding support and education.
- Vouchers for healthy foods.

Eligibility:

WIC serves women and children in families with incomes at or below 185 percent of the federally defined poverty level, who are at risk for nutritional deficiencies. Participant categories consist of the following: pregnant, postpartum and breast-feeding women, and infants and children up to their fifth birthday. Additionally, applicants must be seen by a health professional, such as a physician, nurse or nutritionist, who will determine if the individual is a nutritional risk. "Nutrition risk" means that an individual has medical-based or dietary-based conditions. Examples of medical-based conditions include anemia, underweight or a history of poor pregnancy outcomes.

There are two WIC sites located in the NPU-V. They are bolded in the chart below:

Fulton County WIC Clinic Listing		
Name	**Address**	**City**
Lakewood Health Center	1853 Jonesboro Road, SE	Atlanta
Hapeville Health Center	3444 Clair Drive	Hapeville
College Park Regional Health Center	1920 John Wesley Avenue	College Park
Center Hill Health Center	3201 Atlanta Industrial Parkway, Suite 302	Atlanta
South Fulton Health Center	1225 Capitol Ave, SW	Atlanta
Adamsville Health Center	3699 Bakers Ferry Road, SW	Atlanta
Neighbor Hood Union Health Center	186 Sunset Avenue	Atlanta
Center for Health and Rehabilitation	265 Boulevard Northeast	Atlanta
Aldredge Health Center	99 Jessie Hill Jr. Drive	Atlanta
West End Medical Center	868 York Avenue, SW	Atlanta
West End Medical Center	950 Wilkes Circle NW	Atlanta
Grady Ponce Medical Center	341 Ponce De Leon Ave.	Atlanta
Grady Infant WIC Program	80 Jesse Hill, Jr Dr. SE	Atlanta
Grady Lindbergh Health Center	2695 Buford Hwy	Atlanta
Grady Pediatric WIC Program	80 Jesse Hill, Jr Dr. SE Rm 1220E	Atlanta
Southside Health Center	1046 Ridge Avenue S.W.	Atlanta
Center for Black Women's Wellness	477 Windsor Street, SW Suite 309	Atlanta
South Fulton Medial Center	1046 Ridge Ave.	Atlanta
Grady Maternal WIC Program	80 Jesse Hill Jr. Dr. SE, Room-2H005	Atlanta

2. Screening and Early Intervention Services

- Children 1st

Children 1st is designed as a single point of entry for practitioners serving professionals working in public health programs to make referrals to needed services. Children 1st provides a population- based system of screening young children for specific risk conditions which place the child at risk for adverse health and/or developmental outcomes. The program uses a standardized screening form to identify at risk children. A referral form can be filled out by any individual that is concerned with a child's health or development. Once referred, the child is screened for risk status. Children 1st services are available throughout the state of Georgia and are administered by the local the public health district or county health departments.

- Babies Can't Wait

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. BCW is regulated by Part C of the Individuals with Disabilities Act (IDEA), which guarantees all

eligible children, regardless of their disability, access to services that will enhance their development.

The Georgia Department of Human Services, Division of Public Health is the lead agency administering the Babies Can't Wait Program in Georgia. The Division ensures that:

- Services are provided in accordance with federal guidelines.
- Families have access to the services which are needed to enhance their child's development.
- Training is available to ensure that professionals who work with children and families have up-to-date information.

3. Women's Health Services

- The Center for Black Women's Wellness (CBWW)

The Center for Black Women's Wellness is located in the NPU-V.
477 Windsor Street, Suite 309
Atlanta, GA 30312
(404) 688-9202

The Center for Black Women's Wellness is a not for profit, community-based family service center that provides free and low-cost services to empower black women and their families. CBWW approaches women's health holistically through the use of four components including wellness, maternal and infant health, adolescent health and economic health services.

The Maternal and Infant Health program uses community health workers supervised by a professional social worker. The goal of the program is to provide outreach in the community for pre-natal and post-natal care to reduce infant mortality. Additionally, the program provides home visitation and links to pediatric care.

In response to the primary care shortage in the NPU-V, the CBWW developed a one day a week nurse practitioner operated primary care clinic. Approximately 80 % of the patients at CBWW are uninsured.

The CBWW operates a teen clinic at the center one day a week for adolescents between 10 and 19 years of age. The clinic provides gynecology services, family planning, immunizations and sports physicals. There are no primary care services available to teens.

The adolescent health component of the CBWW provides youth leadership training and is one of the original Plain Talk sites aimed at reducing teen pregnancy.

The goal of the economic health component is to help women understand the correlation between poverty and health. The program involves five weeks of financial literacy training, twelve weeks of business development training, sessions covering legal issues as well as bookkeeping and alumni networking opportunities.

4. Home Visiting Programs

- Project Healthy Grandparents

According to the 2000 U.S. Census Bureau, approximately six million children (8.4%) under 18 years of age were living with non-parental relatives as of the year 2000. Project Healthy Grandparents (PHG) was started in 1995 and is currently funded to assist 45-50 families each year. It maintains an approximate two year waiting list for enrollment. PHG has developed a proven model for working effectively with grandparents charged with the task of raising grandchildren.

The mission of Project Healthy Grandparents is to improve the health and wellness of families in which grandparents are raising grandchildren in parent- absent households. The project is sponsored by Georgia State University, the state of Georgia, federal grants, private foundations, corporations and individuals. Project Healthy Grandparents serves primarily low- income families in south Fulton County, south DeKalb County and Atlanta. The program is open to any grandparent raising a grandchild. Approximately 95% of the past enrollees have been African American and range in age from 42 to 84 years of age.

The project offers services such as home-based nursing and social work, parenting education classes, transportation, grandparent support groups and legal assistance referrals. Additionally, the project offers help for grandchildren to access necessary early intervention services and other referrals for health and education services. All PHG services are offered free of charge to families for one year and transportation is provided to monthly meetings and social events.

A majority of enrolled grandparents have health problems related to aging and poverty. In addition to their own health problems, many grandparents must cope with the medical needs of their grandchildren, including fetal alcohol syndrome, asthma, diabetes, attention deficit and hyperactivity disorder (ADHD) and developmental delays. Many of the grandchildren involved in the project have been neglected, abused or abandoned.

- Parents as Teachers- (PAT)

PAT is a non- profit home-visiting organization that is used by communities to improve the health and well-being of young children and their families. Family involvement in children's learning is a critical link in the child's development of academic skills, including reading and writing. Parents as Teachers trains parent educators to go into the home and educate parents to be their child’s first teacher.

The United Way has supported a small Parents as Teachers program in the NPU-V for a number of years. The Atlanta Civic Site education staff have not found the program to be extremely effective and as a result have recently taken over the management of the program. It is in the process of being restructured to integrate with plans for the new Early Learning Center.

- The Atlanta Healthy Start Program

The Healthy Start Program is designed to provide outreach, care coordination, and health education to pregnant and postpartum women through the following services:

- Outreach to pregnant women and enrolling them into case management services.
- Home visitation.
- Linkage to health and social services.
- Health education through program activities, such as group prenatal care sessions.
- Systems change through the Atlanta Healthy Start consortium which attempts to address system fragmentation and any barriers to accessing resources.

Services are provided through the child's second birthday.

The criteria for the Healthy Start program are:

- Pregnant and living in Atlanta.
- Completion of a psychosocial assessment- clients must score with three risk factors.

The caseload for the Atlanta Healthy Start program in NPU-V and NPU-L is 120 cases and they accept 50 new cases each year. The Atlanta Healthy Start program is operated through the Center for Black Women's Wellness.

- Healthy Families Georgia (HFG)

Healthy Families Georgia is a collaborative effort of Prevent Child Abuse Georgia and the Governor's Office for Children and Families. The HFG program aims to strengthen families and keep children healthy and safe at home. HFG offers expectant and new parents of all socio-economic backgrounds a continuum of services designed to give their babies the best start in life. The services include:

- The First Steps Program offers parenting information, support and connections to community resources starting during pregnancy and continuing through the first three months of a baby's life.
- Assessment is offered to vulnerable parents prenatally or at the time of birth to determine a family level of need for additional services and community resources.

- Home visitation is offered to parents whose assessments indicate a need for additional support through the first years of parenting. Home visitation services are intensive and long-term and may continue for up to five years.
- Screening and assessments for child development.

5. Family Planning Services

Family planning services are available at all of the primary care centers listed in the previous section with the exception of the Aldredge Health Center

6. *Pre-natal Care Services*

Prenatal care services are available at:

- Southside Health Center.
- West End Medical Center.
- St. Joseph Mercy Downtown clinic.
- Neighborhood Union and Lakewood health centers.
- All of the Grady health clinics.

7. *Pediatrics*

Well child care services are available at all of the primary care centers listed in the previous section with the exception of the Aldredge Health Center. Additionally, Grady Memorial Hospital and the Children's Hospital of Atlanta provide a variety of specialty medical care for children.

F. Mental Health Services

1. The Fulton County Department of Behavior Health and Developmental Disabilities
115 Martin Luther King Jr. Dr., Suite 277
Atlanta, GA 30303
(404) 730-0230

The Fulton County Department of Behavioral Health and Developmental Disabilities operates three community-based mental health centers for adults and one for youth and families which provide services to meet the specialized needs of children, adolescents, adults and senior citizens.

The Fulton County Department of Behavioral Health and Developmental Disabilities offers the following range of treatment services:

- Psychiatric assessment and treatment.
- Day services.
- Counseling for groups.
- Co-occurring addiction problems.

- Individual and family therapy.
- Crisis management.
- Parenting training.
- Consultation.
- School clinical services.
- Education and prevention services.
- Coordination of services.
- Referral to appropriate care providers and agencies.
- Continuing care for clients discharged from hospitals.

Adult mental health services are provided at the following locations:

- South Central Mental Health Center (On bus route: #17 from Five Points Marta Station)
  215 Lakewood Way, SW
  Suite 205
  Atlanta, GA 30315
  (404) 762-3650

  Hours of Operation:
  Monday, Tuesday, Thursday & Friday 8:30 a.m. to 5p.m.
  Wednesday 8:30 a.m. to 8 p.m.

The South Central Mental Health Center specializes in mental health services for women through their Women's Health Initiative. This program provides specialized group therapy, life skills, computer training and job search skills to women on TANF (Temporary Assistance to Needy families). Participants in the Women's Health Initiative are recruited through the Department of Family & Children's Services:

- South Fulton Mental Health Center (On bus route: #78 from Lakewood-Ft. McPherson Marta Station)
  1636 Connally Drive
  East Point, GA 30344
  (404) 762-4042

- West Mental Health Center (Bus Route: #165 bus from Hamilton Homes Marta Station)
  75 Fairburn Road, SW
  Atlanta, GA 30331
  (404) 691-9627

  Hours of Operation:
  Monday, Tuesday, Wednesday & Friday 8:30 a.m. to 5p.m.
  Thursday 8:30 a.m. to 8:00 p.m.

Child and adolescent mental health services are provided at the following location:

Fulton County Oak Hill Child Adolescent and Family Center (Bus Route: #95 bus from West End Marta Station)

- Oak Hill Campus
  2799 Metropolitan Parkway
  Atlanta, Georgia 30315
  (404) 762-4111
  fax: (404) 762-4109

  Hours of Operation:
  Monday through Friday 8:30 a.m. to 5p.m.

  Services available:

  - Individual and family therapy.
  - Crisis Intervention.
  - School-based and in-home counseling.
  - Therapeutic after-school and evening program.
  - Anger management groups.
  - Social skills groups.
  - Grief and loss groups.
  - Divorce and trauma groups.
  - Parenting group.
  - Parent and foster parent group.
  - Grandparents raising grandparents group.
  - Therapeutic summer program.
  - Juvenile court based services.
  - Literacy program.
  - Diagnostic assessments.
  - Psychiatric assessments.
  - Nursing assessments.

The Fulton County Department of Mental Health and Developmental Disabilities Treatment Diversion Program is designed to divert individuals with a serious mental illness (and often co-occurring substance abuse disorders) from jail to community-based treatment and support services.

This program consists of three components including a discharge planning unit, a specialized mental health court; and post-diversion services. After clearance by jail and court authorities, a community-based treatment plan is written by a Mental Health Diversion Coordinator and presented in the Mental Health Treatment Diversion Court (TDC) for the approval of the TDC judge. Upon approval of the judge, a defendant

experiencing mental illness can avoid spending a significant period of time in jail on a misdemeanor offense. After release from jail, the individual will be assessed for outpatient mental health and substance abuse services, as well as assigned a case manager who will provide community support and resource coordination.

The individual remains in the program until the TDC judge determines that the compliance criterions have been completed.

G. Substance Abuse Services

The Fulton County Department of Behavioral Health and Developmental Disabilities provides adult outpatient substance abuse services at the new state of the art Center for Health and Rehabilitation. The services include:

- Intensive outpatient counseling.
- Psychosocial day treatment.
- Ambulatory detoxification and rehabilitation.
- Extended care.
- Domestic violence and criminal justice groups.
- Discharge planning.
- HIV counseling, assessment and referral.
- Gender-specific substance abuse treatment.

Addictive services for juveniles are offered at Fulton County Oak Hill Child, Adolescent and Family Center. There are three private substance abuse treatment facilities that provide services to the NPU-V community:

1. Southside Behavioral Lifestyle Enrichment Center
Methadone Services
South Central Mental Health Center
404-762-3650.

2. Bright Beginnings
766 Confederate Avenue
Atlanta, GA 30312
404-289-0313

3. Fulton County A.D.T.C. Ambulatory Detox (Outpatient)
265 Boulevard Avenue
Atlanta, GA 30312
404-730-1661

H. Communicable Disease Programs

1. Department of Health & Wellness
Communicable Disease Prevention Branch

The Fulton County Department of Health and Wellness (FCDHW) has a Communicable Disease Prevention Branch. The Fulton County Health and Wellness Communicable Disease Prevention Branch have four Sexually Transmitted Infections Clinics (STI Clinics):

Adamsville Health Center
3688 Bakers Ferry Rd. SW
Atlanta, GA 30331
404-699-4215

Aldredge Health Center
99 Jesse Hill Jr. Drive
Atlanta, GA 30303
404-730-1401

College Park Health Center
1920 John Wesley Ave
College Park, GA 30337
404-765-4179

Center for Health & Rehabilitation
265 Boulevard, NE
Atlanta, GA 30312
404-730-1650

The STI Clinics offer prevention services, education and counseling, treatment and referrals. The clinics provide:

- Exams for both men and women.
- Testing for syphilis, gonorrhea, chlamydia, trichomoniasis and herpes.
- Lab testing with some results available the same day.
- Mobile unit for some communities, not the NPU-V.
- Attempts to locate individuals with symptoms and sexual partners of patients diagnosed in the clinic.

The Fulton County Health and Wellness Communicable Disease Prevention Branch also operates HIV Primary Care Clinics at the same locations as noted above that offer the following:

- Medical services.
- Complete physical assessment.
- Mental health & substance abuse services.
- Dental services.
- Case management services.
- Health education and support groups.

- Referrals to appropriate providers.
- Peer advocacy counseling.

2. National AIDS Education & Services for Minorities, Inc, (NAESM)
2410 Martin Luther King Jr. Drive
Atlanta, GA 30310
(404)691-8880

NAESM was created to educate communities of color about how to prevent HIV infection. In 1990, there was a severe need for HIV awareness and risk reduction information for the minority community, especially African American men who have sex with men (MSM), which continues to be one of the most infected and affected communities today. NAESM conducts risk reduction workshops, street level community outreach, case management, safer sex packet distributions, public service announcements and advertising to promote a healthy lifestyle. All services are strictly confidential.

3. Da C.R.I.B.B. (Creating Rich Intelligent Black Brothas)
2410 Martin Luther King Jr. Drive
Atlanta, GA 30310
(404)691-8880

Hours of Operation:
Wednesday through Saturday 12 p.m. to 9 p.m.

Da C.R.I.B.B. is a drop-in "safe space" and educational resource center for young gay and bisexual men of color. Da C.R.I.B.B. empowers and educates by providing interactive and educational resources to help young men make healthy lifestyle decisions. Some of the educational and health resources are the following:

- The Mpowerment Project mobilizes gay and bisexual young men to shape healthy communities and build positive social connections and support safer sex.

- Mental health counseling is provided on a drop-in basis by a licensed social worker to address clinical depression, family issues, societal barriers and substance abuse.

- Comprehensive risk counseling services are provided by a Life Support Counselor whose role is to assess high risk behaviors and create strategies for short and long term goals for personal risk reduction.

4. Open Arms
4000 Roswell Road,, NE
Atlanta, GA 30342
(404) 256-1330

Opens Arms provides transitional housing for persons living with HIV/AIDS, including transgendered persons.

I. Services to At-Risk Teens

1. Plain Talk

The Plain Talk program is a youth development program, originally developed by the Annie E. Casey Program Foundation, which is provided by the Center for Black Women's Wellness. It includes four core activities to address adult and teenage sexual risk-taking for the reduction of teen pregnancy, STDs and HIV/AIDS:

- Askable Adult Workshops- an eight session workshop focuses on educating parents and other adults on the critical issues of adolescence such as puberty, peer-pressure and relationships.
- Living Room Party Host Training -After completion of at least five of the workshop sessions, participants began Living Party Host Training where they have the opportunity to share the information learned in the workshop with peers.
- Living Room Parties- Living room hosts sponsor parties in their homes where they invite their friends who are fellow parents to learn about risk reduction strategies to employ with their children.
- Summer Youth Leadership Training Program- An eight week program that provides valuable life skills training and leadership development to males and females ages 10-15. Some of the issues addressed are teen pregnancy, and the spread of sexually transmitted diseases, including HIV.

J. Community Outreach and Disease Specific Programs

1. Asthma

- TEACH- Together Educating Asthmatic Children on Health

This program is managed by the Fulton County Department of Health and Wellness. The initiative has a focus on educating children and their families on the dangers of asthma and provides interventions in homes that can reduce the risk of asthmatic attacks. The initial phase of the program had two major efforts including in-home assessments and smoking cessation workshops.

- The Children's Hospital of Atlanta Asthma Center

This specialty outpatient center offers the highest quality of care available in the area for children with asthma.. Each patient is provided an individualized treatment plan. The type of treatment needed depends on the severity of the child's condition and the physical environment in which they live. Respiratory issues are the primary reason for admission to Children's Hospital in Atlanta.

- Southside Health Center Asthma Initiative

A new program operated by the Institute of Public Health at Georgia State University, this initiative provides education and in- home assessment to patients of the health center suffering with asthma. Utilizing community health outreach workers, the program offers a series of educational sessions to help parents of children better manage their child's asthma. In home assessments help identify environmental irritants and assist parents in ways to reduce or eliminate triggers.

- The Georgia Comprehensive Sickle Cell Center at Grady
  Located at the Grady Memorial Hospital
  (404) 616-3572

The Georgia Comprehensive Sickle Cell Center at Grady is a primary care clinic for patients with sickle cell syndromes. There is 24 hour urgent care available to all patients 16 years of age and over.

- The Grady Diabetes and Detection Control Center
  Located at the Grady Memorial Hospital
  (404) 616-2645

The Grady Diabetes and Detection Control Center specializes in diagnosing and treating patients with diabetes.

2. Community Outreach

- Health Works- the Center for Working Families, Inc.

Health Works is a program operated by Morehouse Medical School and employs community health workers to educate participants of the Center for Working Families on important health topics. Health Works sponsors a series of lunch and learns based on the following four health topics:

  - Diet, exercise and smoking.
  - Access to health care.
  - Mental health.
  - Emergency preparedness.

The learning sessions are taught on a third grade level to allow all residents of the community to gain a better understanding of their health and available health resources in the community. Additionally, the health workers refer and link participants to health services.

K. Advocacy and Policy Organizations

1. Voices for Georgia's Children

Voices for Georgia's Children is an independent non-profit organization working to impact the lives of Georgia's children in five distinct areas: health, safety, education, connectedness and employability. The organization performs advocacy, original research and analysis, to assist leaders and citizens of Georgia in making sound decisions on policy, investment and systems that serve children and youth. In so doing, Voices for Georgia's Children can produce better outcomes through supportive public policies and adequate public and private resources.

The organization has made a long term commitment to improving the health status of children with a focus on the following five indicators:

- Low birth weight babies.
- Timely immunizations.
- Oral health status.
- Obesity.
- Adolescent health.

2. Georgia Early Childhood Comprehensive Systems Program

The purpose of the Early Childhood Comprehensive Systems Program (ECCS) is to support state maternal and child health agencies along with their partner organizations as they work together to develop a more comprehensive early childhood system. Georgia has a vast array of early childhood programs and initiatives to improve outcomes for children birth to age five. The ECCS acts as a catalyst for discussion between state agencies on how they can work better together to create a system that supports the health, safety and well-being of the state's youngest children.

An Early Childhood Comprehensive Systems strategic planning grant from the Health Resources and Services Administration (HRSA) will support the development in Georgia of a comprehensive early childhood service system that integrates access to health insurance and a medical home, mental health and socioeconomic development of children, early childcare and education, parenting education, and family support. A major emphasis in this upcoming strategic plan is to improve access to evidence-based developmental screenings in both traditional and non-traditional early childhood settings.

VII. Gap Analysis

The above inventory and profile of health services and supports for young children and their families in the NPU-V reveals a significant number of strengths and gaps that have implications for future planning on how best to improve the health of the children and their families in the NPU-V. The following is a summary of the major gaps in services identified through the inventory of services:

1. **Assistance with enrollment in health insurance and selection of a medical home**. With the exception of the Center for Working Families, Sheltering Arms and other outreach provided by the Atlanta Civic Site, there are no community-based outreach workers to assist NPU-V parents in applying for public benefits. While Southside Health Center and the other health centers serving the community offer assistance, families generally are not accessing these clinics if they do not have health insurance. As indicated in the neighborhood profile, 50% of children in the three zip codes comprising the NPU-V lack health insurance, despite income levels that would warrant their eligibility in Medicaid or PeachCare for Kids. The application process for Medicaid and PeachCare is complicated and requires families to be able to understand the instructions, have available documentation and access to a computer or post office to enroll. With the numerous stressors facing daily life of families in the NPU-V, having the ability to complete the application process without assistance is very unlikely. The lack of assistance in accessible locations in the NPU-V is preventing many children and families from obtaining health insurance, a critical foundation for receiving health services.
2. **Availability of accessible and culturally competent primary care services.** There is only one primary care health center available to serve the entire NPU-V community. Many residents do not use Southside citing high co-payments and other access issues. While the health department has recently created the new Neighborhood Union Health Center, its location is not very accessible to NPU-V residents. Transportation is difficult in Atlanta and therefore accessing services outside the neighborhood is a major barrier. The historical pattern in the NPU-V is to use the Grady Emergency Department. As a result children without a regular source of primary care are not receiving their immunizations, developmental screenings and regular physical examinations to detect and treat childhood illnesses. Without a source of medical care, parents are not having chronic illnesses managed and are therefore not functioning in optimal health to be able to care for their children.
3. **Adequate school health services**. With only part-time nurses in the elementary schools and no nurse in the high school, NPU-V students can not have their health needs sufficiently met. Issues with chronic diseases, such as diabetes and asthma that impact attendance can not be adequately addressed with only part-time school nursing services. Health education to children and families is not feasible given the limited school health nursing support. The lack of available school health services in the high schools is a major issue

especially in a community with such high rates of teen pregnancy, HIV and substance use. The availability of school-based mental health services is also sorely lacking contributing to the major social emotional issues that the residents themselves cite as very prevalent among neighborhood children.

4. **Intensive support to pregnant women and young children, especially to teen mothers.** While there are a number of home visiting programs that serve the NPU-V, the number of families accessing these services is far below the need. The birth outcome data reported in the Neighborhood Profile section indicate that NPU-V pregnant women need assistance in accessing pre-natal care earlier and on a regular basis and education on how to have a healthier pregnancy that can yield the best chances for a healthy birth. Recent increases in the teen pregnancy rate provide an even greater need for supportive services. The high rates of infant mortality indicate that families need continued assistance once the baby is born in learning how to more effectively care for and nurture infants and young children. Alarming rates of child abuse and neglect even further validate the need to help families with the youngest children by providing the guidance and support needed to have children start off with the best chances for optimal growth and development. While the Children 1st system of universal screening is conceptually sound, the number of families being identified does not appear to match the need. Even when families are identified by Children 1st, they receive very limited support which is insufficient to meet the multitude of complex needs faced by families from pregnancy through the child's second or third birthday.
5. **Services targeting adolescents to prevent teen pregnancy, STD's, mental health and substance abuse problems.** There are a lack of programs in schools and recreation centers that provide health education aimed toward positive youth development and risk reduction.
6. **Limited screening, education and support for depression and other for mental illness.** The medical model of diagnosis and treatment available on a limited basis in the health centers serving NPU-V residents does not address the significant need and stigma associated with mental health problems. NPU-V residents report high rates of anxiety and depression that might be more effectively treated through interventions built on social support systems and networks. With the exception of the limited counseling services offered by the Center for Black Women's Wellness, there are no other culturally relevant treatment options available to NPU-V children and families. Screening for maternal and childhood depression is not widely available, therefore families with mental health issues are not being identified and receiving help.

VIII. Interviews

Two site visits to the Atlanta Civic Site were conducted in order to interview key stakeholders associated with community and public health agencies to obtain input into the health needs of young children and their families. The following stakeholders were interviewed:

- Bacon, Rosalyn, Director, Department Human Resources, Office of Birth Outcomes.
- Bauer, Debra, Consultant and Organizer, The Early Childhood Comprehensive Systems (ECCS).
- Cooper, Juliet, Nursing Director, Fulton County Health and Wellness.
- Dorsey, Jemea, CEO, Center for Black Women's Wellness, INC.
- Dowd, Brian, Director Member Services and Policy, The Department of Community Health.
- Fergeson, Liz, Vice-President of Programs, Prevent Child Abuse Georgia.
- Harris, Patrice A., Medical Director, Department of Mental Health Developmental Disabilities and Addictive Diseases.
- Howgate, Jamie, Director, Division of Population Health Fulton County Public Health.
- Landers, Glen, Senior Research Associate, Georgia Health Policy Center.
- Lattimore, Barbara J., Director, Fulton County Department of Mental Health Developmental Disabilities and Addictive Diseases.
- Lewis-Hardy, Ruby, Health Program Administrator, Fulton County Department of Health and Wellness, Communicable Disease Prevention Branch.
- Malavenda, Roberta, State Leader, Parents as Teachers.
- McCreary, Jennifer, Managing Director-Moving to Work, The Center for Working Families.
- Medows, Rhonda, Commissioner, Georgia Department of Community Health.
- Meyers, Kate, Director of Family Services, Sheltering Arms.
- Mobley, Sabrina, Prince, Dorian and Dukes, Katia, Community Health Workers, Morehouse Medical School.
- Monroe- Green, Katrina, Family Support Coordinator, Sheltering Arms.
- Perdue, Judy, Community Partnerships Coordinator, Project Healthy Grandparents.
- Salters, Armstead, Principal, Gideon's Elementary School.
- Waits, Lauren, Policy Director, Voices for Georgia's Children.
- Wilkens, Huxie, Vice-President of Programs, The Center for Working Families.

The following is a summary of the common areas of concern and perspectives on health priorities reported by the above interviews:

1. The residents of the NPU-V have limited access to primary care due to a shortage of practitioners in the area, transportation issues, lack of health insurance and cost.
2. Mental health is a major issue in the NPU-V with conditions ranging from mild depression and anxiety to major conditions such as bipolar and schizophrenia.

These issues remain largely unaddressed due to African American culture, a lack of mental health providers and the cost associated with care.

3. Substance abuse was generally not acknowledged as a major issue among residents of the NPU-V. However, there was agreement around wide spread substance use which indicates a level of community normalization around this issue.
4. The community lacks a comprehensive continuum of care to support pregnant women and families with young children.
5. HIV/AIDS is a major health issue particularly for with men-seeking-men (MSM). Increased attention needs to paid to risk reduction.
6. There is widespread agreement that Grady emergency department is the residents preferred setting for receiving healthcare services. This appears to be a historic and deep-seeded behavior.
7. School health services are insufficient to meet the needs of students. School health providers feel unable to address the magnitude of health and family issues due to inadequate staffing.
8. Adult residents generally neglect their health, yet suffer from chronic illnesses such as hypertension and diabetes.
9. Domestic violence is an increasing problem in the NPU-V. Rates are increasing due to a variety of environmental stressors, such as, financial, health and housing in the NPU-V.
10. The level of family stress was consistently cited as a major factor in parents ability to optimally care for their children.
11. There is a shortage of recreational activities for young people in the recreation centers, schools and churches.
12. There is no place in the NPU-V to purchase healthy food.
13. Community health providers acknowledge a lack of knowledge of each other's services and working relationships that would facilitate better coordination of care.

IX. Summary and Recommendations

The findings of the Neighborhood Profile and Gap Analysis reveal a number of clear health priorities for NPU-V children and families that could be addressed by the Atlanta Civic Site in the future as it plans to integrate health interventions into its overall strategy to improve the quality of life for families.

NPU-V children and families confront a multitude of challenges related to improving and maintaining good health. The high rates of poverty, unemployment, and low educational attainment contribute to a number of disparities in health status that are evident in the population. Neighborhood factors, such as poor and blighted housing, lack of green and open spaces and insufficient access to nutritious foods further contribute to the challenges that NPU-V families face in trying to live a healthy lifestyle. Finally, a lack of access to critical health, education and support services prevent children and families from receiving the health care necessary for healthy growth and development and overall well-being.

Given these numerous issues, there are many areas that the Atlanta Civic Site could focus its future interventions in order to impact the health status of families. However, given the current work of the Atlanta Civic Site focused on families with young children and its significant progress in advancing the academic achievement of students, there are a number of important health priorities and accompanying strategies that are initially recommended to addressing health status improvement.

The following are the recommended initial priorities and strategies for the Atlantic Civic site to focus its initial health work:

1. **Increase the number of children in the NPU-V that are insured and have a medical home.** As indicated previously, significant numbers of NPU-V children lack health insurance and income levels indicate that the majority of these children are most likely eligible for Medicaid or PeachCare for Kids. The Gap Analysis identified a lack of sufficient community-based assistance available to families, with the exception of the existing support provided through the Center for Working Families and other Atlanta Civic Site programs and partners. Having health insurance is a fundamental first step to helping children access needed health services. Without insurance, children are not able to access a regular source of primary and preventive care. However, coverage alone is insufficient to address access. Because Medicaid and PeachCare for Kids require assignment to a managed care organization, families need to select a primary care provider or PCP as their source of health care. Without assistance, families often complete the application process to Medicaid and/or PeachCare for Kids and do not select their PCP, leaving the managed care organization to "auto assign" the child to a PCP that may not be accessible to the family. Therefore, families need assistance with the application process as well as the selection process for a PCP. This help with enrollment and selection of a PCP could be provided through "Walkers and

Talkers" or trained community residents who could be stationed at strategic locations throughout the community, such as in schools, laundromats, beauty shops, child care and early education programs, churches, grocery stores and other community sites frequented by parents.

2. **Educate parents on the need for primary and preventive care for their children and assist in linkage to services.** As indicated above, having health coverage and an assigned PCP on an insurance card does not translate into parents actually using the PCP as a regular source of primary and preventive care for their children. Interviews with community residents and health care providers consistently revealed that NPU-V residents have a long standing practice of using the Grady Hospital Emergency Department as their source of health care. This is a behavior that needs to change and is impacted by cultural beliefs, values and a general lack of education about the value and benefits of primary and preventive health care beginning at birth. Families that understand the need for primary and preventive care most likely need assistance accessing these services given that most of the health centers are located outside the neighborhood with the exception of Southside. Helping families with transportation, issues with childcare, making appointments and other needs is critical to assuring that children actually link to primary and preventive care. These services could be provided through the use of community outreach workers or the same "Walkers and Talkers" as above, trained to educate and help their peer parents in the neighborhood.
3. **Provide outreach, education and support to pregnant women and families with young children, especially teen mothers to improve birth outcomes and assist in supporting early healthy growth and development.** While children of all ages need health services and support, the early years are a critical period of growth and development that is impacted by parental nurturing, support and access to health services and supports. Building on the strong commitment that the Atlanta Civic Site has and continues to make to families with young children, it is recommended that additional outreach and supportive services be provided to new and existing families to promote improved birth outcomes and healthy growth and development. Services might include community outreach to identify pregnant women, especially teen mothers through door to door outreach and partnerships with schools, community centers and churches. Expanding partnerships with the existing home visiting programs, such as Healthy Start at the Center for Black Women's Wellness and the Healthy Families Program could provide the intensive education and support needed by additional vulnerable pregnant women and families with young children. Adding parenting education and family support services to the planned Early Learning Center and in other accessible locations in the community would help parents gain the skills needed to better care for their infants and young children, as well as assist them in accessing other critical services, such as pre-natal care, well child care and developmental screening.
4. **Increase the availability of evidence-based developmental screening and follow-up support for young children ages birth through three in non-traditional locations such as community WIC sites, child care and early education programs, churches and other sites highly frequented by families**

with young children. Access to evidence-based developmental screening using instruments such as the Ages and Stages Questionnaire (ASQ) and the Parents Evaluation of Developmental Stages (PEDS) is recommended by the American Academy of Pediatrics to provide effective screening for developmental delays at critical age milestones beginning at birth. Given that large numbers of NPU-V children do not access regular primary and preventive care in the early years, it is unlikely that they are receiving developmental screening. Therefore, a delay may not be undetected until the child reaches kindergarten. Once children begin elementary school, most developmental delays are not detected unless children demonstrate academic failure or significant behavior problems. Developmental screening does not take long to administer and can be conducted using trained community residents and other individuals that work well with children.

5. **Increase the availability of maternal depression screening and support services in community sites such as the Center for Working Families, child care and early learning centers, WIC sites, churches, schools, and partner health centers.** Given that community residents cite mental health issues as a major problem and the experience of the Center for Black Women's Wellness in identification and treatment of maternal depression, there is clear support for the need to expand the identification of mothers suffering from depression and alternative treatment options. Like developmental screening, there are a number of evidence-based screening instruments, such as the Center for Epidemiological Studies Depression Screen (CES –D) that are simple and not time consuming to administer. These screens usually entail a short number of questions that can be administered by a trusted peer, professional, provider or can be self-administered. The screening in community sites, especially in WIC sites where large numbers of pregnant and post-partum women frequent would help increase the identification of women in need of additional support. Additional options for treatment, developed in partnership with the churches, the Center for Black Women's Wellness and other culturally competent, trusted organizations would need to be created to respond to needs identified through the community screening. Given the stigma surrounding mental illness, non-medical model programs that rely on social networking and peer support should be considered.
6. **Increase the availability of school health services.** Given the strong focus on education achievement that the Atlanta Civic Site has implemented over the last five years, addressing the gaps in school health services, especially in the high school would strengthen the efforts to improve academic performance and provided needed risk reduction education.
7. **Develop a structure and process to facilitate community-level planning for integrated and collaborative health service delivery.** The Atlanta Civic Site's leadership role in impacting community change in the NPU-V could be leveraged to facilitate the development of a new collaboration between health service providers that serve the community. Public health leaders and providers acknowledge the need for better communication and enhanced partnership to reduce service duplication, address service gaps and promote a higher level of service integration. The Atlanta Civic Site could help convene leaders from health service organizations to begin discussions regarding how to improve

working relationships and assist in development of a strategic plan to improve the health of NPU-V children and families.

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